Flex Success

Success Stories of the Rural Hospital Flexibility Program

Clockwise from top: St. Vincent Randolph Hospital – Winchester, IN; Kearny County Hospital – Kearney, KS; Samaritan North Lincoln Hospital – Newport, OR

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SECTION 1

Flex Success Stories from Critical Access Hospitals and State Flex Programs

ST. VINCENT RANDOLPH HOSPITAL • WINCHESTER, INDIANA

Submitted by: **James M. Full, FACHE, Administrator**

St. Vincent Randolph Hospital is a primary care, rural hospital and health system with an 83-year history of caring for the area's 27,000 residents. It is located in a community of 6,500 residents.

In September 1999, Randolph County Hospital was designated as a Critical Access Hospital, the second in Indiana. Due to limited resources and reductions in reimbursement, the hospital's Administration, Board of Directors and Medical Staff recognized the need to affiliate with a tertiary care hospital. The physical plant was also antiquated and not designed for 21st century health care, and our organization did not have the resources to replace this building. In November 2000, Randolph County Hospital affiliated with St. Vincent Hospital in Indianapolis (one of the top 100 hospitals in the country), and changed its name to St. Vincent Randolph Hospital. On July 1, 2000, Randolph County Hospital merged with its network hospital and as part of this affiliation, St. Vincent's agreed to construct a $15.6 million hospital, the first hospital nationally specifically designed to be a Critical Access Hospital. The local community donated 32 acres toward the new site, and the new hospital has been operational since November 2001. The hospital's revenue has increased 24% during the first year of this affiliation.

Cardinal Health System, a tertiary care hospital 30 miles east of our facility, was a major threat and competitor to our organization for decades. Over the past two years, the three organizations have come to the table to explore ways to reduce duplication of, and expand services locally for the benefit of our local rural residents.

Last year, the Cardinal Health System and our Hospital merged our Home Health Care programs in Randolph County so there would be less duplication of services in our area. The Cardinal Health System now oversee the daily operations of this program and lease space owned by our facility. They also lease our employees and reimburse us for their salaries/benefits. Bills are sent out under Cardinal Health's provider number, and the new Home Care Agency was renamed "Randolph County Home Health Care."

Also last year, our Rural Health Clinic and the Cardinal Health System's satellite medical office in Union City merged under the operational control of the St. Vincent Randolph Hospital Rural Health Clinic. Our clinic moved into a larger building and is subleased from the Cardinal Health System. Their physician is subleased by our organization. Radiology, an Eye Clinic and Mental Health Services were added to the Rural Health Clinic. These actions have eliminated the duplication of services and improved the coordination of services in our area.

In conjunction with our improved relationships with our competitors, our organization, Cardinal Health System and St. Vincent Hospital collaborated to provide Mental Health Services in the area. Two Clinical Social Workers have been provided by our network hospital, the Cardinal Health System has provided a Psychiatrist twice a month, and we provide space and bill through our Rural Health Clinics.

Cardinal Health System and St. Vincent Randolph Hospital are partnering to bring Dialysis Services and Cancer Services to Randolph County as well. Cardinal Health will be providing Chemotherapy services five per week to area residents. St. Vincent Randolph will provide Cancer Prevention Educational Programs in the community and in all the area schools. This facility will open in November 2001.

Other areas where our two organizations are partnering include Continuing Medical Education for our physicians and associates, rotation of Medical Residents through our four model Rural Health Clinic and Training Centers, and the provision of Emergency Room Physician Coverage at our hospital.

ST. HELENA PARISH HOSPITAL • GREENSBURG, LOUISIANA

Submitted by: **J. Scott Stafford, Chief Executive Officer**

St. Helena Parish Hospital became Louisiana's first Critical Access Hospital in November 1999. Our service area consists of about 10,000 people. Our service area per capita income is approximately $11,000/year. Our demographics consist of about 60% of our population over 65 years of age. We are the sole major industry and employer in the region. To highlight the rural area, our parish/county does not have one red light within its boundaries.

Before becoming CAH, our hospital posted a substantial operating loss in 1998. Under our first year as a CAH, we reduced that loss by 90%. Seven months into our second year as a CAH, we are posting a good-sized profit. A majority of this profit is due to an Intergovernmental Transfer Program for the hospital and nursing home, but nonetheless, we have demonstrated a $1.2 million dollar turnaround in 1.5 years under CAH and other programs.

Of course, we are pleased with these accomplishments, but more importantly, I want to elaborate on the services, quality, and community impact we have gained under the CAH Program.

- Emergency Room admissions have increased by 50%, mainly due to new equipment, qualified physician coverage, community acceptance that our ER will be open, and staff training.
- Outpatient services have increased by 75%, mainly due to the addition of an outpatient department, services, and staff training.
- Our inpatient census remains about the same, but we have increased swing-bed usage, observation stays, and telemetry.
- We have improved EMS in our area. The closest EMS service is approximately 20-30 minutes from most of our service area. We have used an available grant to train local fire departments, police departments, etc. in first responder training to improve patient outcomes before an ambulance arrives. We also have used the grant to train all our nursing staff, physicians, and ancillary staff in ACLS and PALS certification and will be working towards trauma, farm accident training for our staff. We also provide community CPR training. Our goal is to have one person in every household in our community trained in CPR.

- We have opened a same-day surgery clinic for the community, new telemetry services, new in-house laboratory testing, life support equipment, patient monitoring equipment, new radiology/ fluoroscopy services, and a CT scanner in the near future.
- We have expanded Performance Improvement Programs to include process teams, patient pathways and protocols.
- Through our network agreements, we have become a transfer site for other facilities' emergency rooms during times of diversion to address overcrowding of ER's with our network facilities.
- We also have been able to recruit and retain staff as well as address current staff needs with improved salaries, unique benefit packages, new orientation program, and staff education opportunities.

One of the things I am personally proud of is that we improved all of these services, equipment, and benefits, but yet kept our expenses the same as they were prior to becoming a CAH by assessing certain service lines, cost-saving programs, and improved contractual agreements.

As you can see, we have a very powerful success story as a CAH facility, especially since we were the first in our Fiscal Intermediary's region. We are not satisfied; we are in the process of looking at the HUD 242 Loan Program to better address our aged facility. We are looking at a new charity-care program with our state offices similar to the old Hill-Burton Program. We are also looking at new outpatient services, quality initiatives, and expanding EMS and our networks.

GARRARD COUNTY MEMORIAL HOSPITAL & LONG TERM CARE FACILITY • LANCASTOR, KENTUCKY

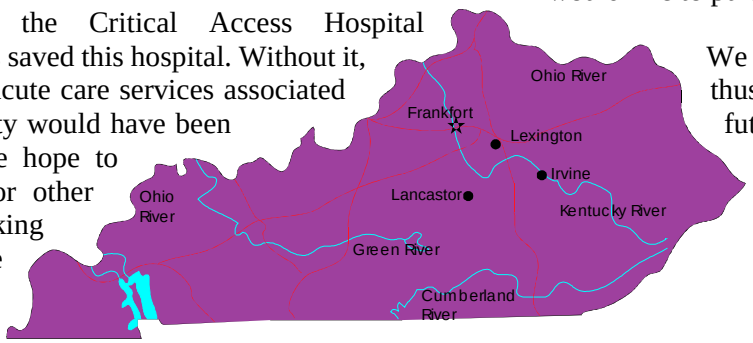
Submitted by: **Chris Wearmouth, Interim Administrator**

Garrard County Memorial Hospital became the first hospital in Kentucky to convert to a Critical Access Hospital. We are beginning to see the impact of the conversion and can begin to talk about the future once again. While we still operate with a negative bottom line, we can see a light at the end of the tunnel due to the change in reimbursement.

In the past, it has been typical for this facility to lose money each month and that is with positive contributions from the nursing home portion of the operations. Currently we are experiencing minimal losses and expect to be in the black in two months. The hospital will operate at near break-even levels due to the new reimbursement rates and the long-term care facility will post profits.

The Critical Access Hospital program has also been the basis for additional funding from our conventional sources. With our improved rates, we have been able to obtain an additional $2.5 million dollars in loans to retire old debt and start anew.

In summary, the Critical Access Hospital designation has saved this hospital. Without it, I am sure the acute care services associated with this facility would have been terminated. We hope to be a model for other facilities looking to pursue the same strategy.



MARCUM & WALLACE MEMORIAL HOSPITAL • IRVINE, KENTUCKY

Submitted by: **James E. Holtzenrater, CHE, Administrator**

Marcum & Wallace Memorial Hospital became a Critical Access Hospital on July 13, 2000. The conversion to a CAH has accomplished one of the most important factors for a small and rural hospital – provided cash. Our cash flow has not only improved, but there has been a positive turnaround in our financial viability. Our cash on hand has gone from 2-3 days to 38 days.

Another very important factor in our conversion was the ability to adjust wages, particularly for hard-to-recruit-and-retain positions. We have been able to retain over one third of our nursing staff, who already had other jobs, by making the salary and benefit adjustments. This would not have been possible if we had not become a CAH.

Even though we are part of two different networks, Mercy Health Partners and Bluegrass Health Alliance, the networking concept of CAHs has encouraged us to go even further. The networking concept is one area we need to further develop and would like to pursue.

We are very pleased with our progress thus far and see nothing in the near future that would change our minds.

KEARNY COUNTY HOSPITAL • LAKIN, KANSAS

Submitted by: **Chris Tilden, Rural Health Program Director, Kansas Office of Local & Rural Health Systems**

As the name suggests, Kearny County Hospital is owned by the county. With its 26 licensed acute care beds, the hospital shares a campus with a county-owned nursing home that has 40 long-term care beds and 25 assisted living beds. For many years the hospital and nursing home maintained separate governance structures, but they consolidated in 1999 to secure appropriate financing for a major building project that is nearing completion. There is now one governing board and all administrative and support services functions are jointly operated. The building project physically connected the two facilities and has allowed for the consolidation of dietary services.

Kearny County Hospital is a Critical Access Hospital, which previously had been licensed as a rural primary care hospital (RPCH) under the Essential Access Community Hospital (EACH) Program. The decision to convert from "full-service-hospital" status to RPCH status was not made lightly. Hospital leaders harbored considerable anxiety about participating in an evolving federal program. In the second wave of hospitals in Kansas to convert to RPCH status (late 1996), Kearny County Hospital became a RPCH only after evaluating the performance of other Kansas RPCHs and undergoing a financial feasibility study.

Today the hospital offers radiology, laboratory, physical therapy, in- and outpatient surgery, low risk obstetrics and 24-hour emergency room services, in addition to acute care and long-term care in swing-beds. The hospital is also served by mobile technologies – ultrasound, mammography, osteo-porosis screening, and CT.

Kearny County Hospital, by consolidating with the nursing facility and by networking with many local and regional partners, has significantly increased its diversity of services to become the lynchpin for a system of integrated health services delivery in Lakin. Primary care services were integrated with the hospital when the Family Health Center was built. While the hospital no longer employs the primary care physicians in the community, the hospital and physicians have a positive, collaborative relationship and work together to provide the most efficient primary care services possible while avoiding possible duplication of effort. The county-owned ambulance service maintains a separate governance structure, yet operationally it has been integrated into the hospital. By providing space and staff, the hospital influences the delivery of home health services in the county without owning them. By providing space to the retail pharmacy in the hospital, Kearny County Hospital assures the availability of pharmacy services not only to itself and the nursing home, but also to the primary care practice, and the entire community.

The success of Kearny County Hospital at integrating these elements of care illustrates that it is not necessary to own all of the elements of an integrated delivery system to offer the residents of a service area a seamless continuum of services. The benefits of local integration are mirrored in the success the hospital has had in establishing regional relationships. Through telemedicine and formal network relationships, Kearny County Hospital has been able to leverage resources and bring network solutions to bear on both local and regional challenges to enhance healthcare services. The hospital believes it is best able to serve the community by having open lines of communication among all of the providers in the community, within the residents of the community to continually evaluate needs, and with neighboring health care providers to encourage and participate in the sharing of services.

The environment of Kearny County Hospital is constantly changing. Through community leadership and network collaboration, they are facing head-on the challenges and opportunities presented to it.

OUR COMMUNITY HOSPITAL • SCOTLAND NECK, NORTH CAROLINA

Submitted by: **Robert R. Waters, Jr., OCH Board Member**

Our Community Hospital is a 100-bed facility consisting of 20 acute care, 60 skilled and 20 home for the aged beds. In addition, we have 24-hour emergency room overage and a lab and x-ray department. The campus also has an adjoining clinic staffed by two mid-levels and two physicians. The Town of Scotland Neck has a population of approximately 2,100 people but our service area contains about 15,000 citizens.

The biggest advantage of becoming a Critical Access Hospital for us has been in reimbursement especially for ancillary services, which I am sure is the case for most CAHs. It has also allowed us to be very flexible in our services. For example, even though we have to provide certain services, they do not have to be done in-house, for example CT scans and our emergency room. This has allowed us to save considerable cost. Another big advantage has been the ability to pass the lease of capital equipment through as cost.

I think everyone on our Board would agree that the ability to align with a large facility so that it makes it beneficial for both facilities has been a huge plus. By becoming a CAH we have been able to keep our emergency room open 24 hours a day, 7 days a week. In the eyes of the citizens we serve, this ability to maintain ER coverage has been, and will continue to be, the service they expect the most.

One item that we are currently evaluating is the possibility of assuming ownership of the adjoining clinic and operating it as part of the hospital. We believe that this may have some positive financial results.

As far as lessons learned, I would have to say take tiny steps but also be willing to examine and consider all new avenues that become available. Each facility is different and every area has it's own unique needs. For example, for several years we ran our Emergency Rescue Services as a department of the hospital, but finally decided to become part of a countywide service. This has enabled us to provide paramedic coverage to every citizen of not only Scotland Neck, but also the entire County of Halifax.

BEAR LAKE MEMORIAL HOSPITAL• MONTPELIER, IDAHO

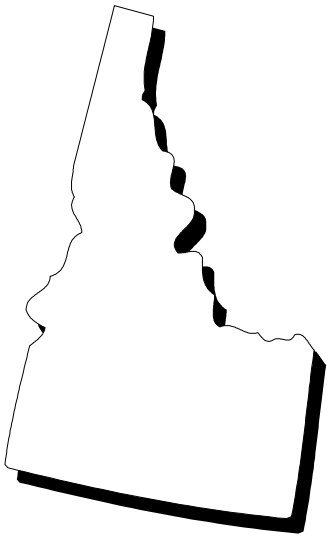
Submitted by: **Ron Jacobson, Administrator**

Bear Lake Memorial Hospital is a 21-bed hospital located in a mountain valley in southeast Idaho. We serve approximately 8,000 residents. The next closest hospital to which we can transfer patients is 70 miles away, crossing a 7,500-foot mountain summit. Aside from our school district, we are the largest employer in the county and by far the largest that is not heavily tax supported. Our patient base is significantly older and financially poorer than state or national averages.

The entire healthcare system for our community depends on the viability of the hospital. It is the hospital that recruits and establishes physicians, educates and employs nurses, supports the EMS system, offers preventive services, etc. We offer a wide array of services including obstetrical, surgical, long-term care, acute care, mental health services, home health, rural health clinics, physical therapy and diagnostic capabilities. In short, without this hospital there would be no healthcare services to the residents of Bear Lake County.

Bear Lake Memorial Hospital recently celebrated its 50th anniversary of continuous service to the residents of Bear Lake County. The Hospital receives a very limited amount of local tax support (2% of our budget) and we have managed to break-even or eke out a very small profit over the past 10 years. The Rural Hospital Flexibility Program has made it possible for us to bring in a hospital finance specialist to help us develop a computerized budgeting system so now we can more accurately know which departments are profitable and what we can do to improve those that are not. We have been able to bring in a specialist in strategic planning and our Board spent two full days laying out a "blue print" for where we are and where we want to be.

We have also been able to send four of our Board members to a Board Trustee Symposium for leadership development thanks to a Flex grant. Were it not for the coaching and instructions we received from the Idaho Hospital Association to help us pass our Critical Access Hospital Survey, we would have never made it through the inspection. The people from IHA that coached us were funded through the Flex Program!



Our state's Rural Hospital Flexibility Program is very well staffed and managed. Virtually every small hospital is aware and takes advantage of the program. The networking and dialogue that takes place between rural hospitals in Idaho has never been better thanks in great part to the Flexibility Program.

BENEWAH COMMUNITY HOSPITAL • ST. MARIES, IDAHO

Submitted by: **Camille A. Scott, RN, MA, CNNA, CEO/Administrator**

Benewah Community Hospital/St. Maries Family Medicine is a 15-bed acute/10 swing healthcare facility located in a rural section of northern Idaho. The city population is 2,300 and Benewah County is approximately 9,000. Ninety-five percent of the job market is affected directly or indirectly by a highly volatile timer industry. The instability of the timer market dramatically affects our health system in many ways: staffing, services, financial, and overall functioning.

The high cost of operations is driven by our rural setting, lower patient volumes, high number of uninsured patients and 50-60% of our business is reimbursed by Medicare/Medicaid. These are the factors that make rural healthcare a fragile product. Monies from operations at times are not enough to pay our bills. Like all rural hospitals, the bad debt is climbing, expenses are soaring but reimbursement is dwindling. Yet, being located in a remote mountainous area 55 miles from the next acute care hospital, the need to remain open is imperative. We cannot accomplish this goal without help.

The help we have received to make our survival even possible has been from the Medicare Rural Hospital Flexibility Program along with a "Recruitment/Retention Grant" from the State Office of Rural Health to attract new and keep the current physicians we have.

Changing to a Critical Access Hospital (CAH) in July 2001 was imperative for our survival. Rural hospitals have the same expenses and requirements as urban hospitals but significantly lower volumes to support the high costs of providing services. This results in high costs and low revenues. The CAH designation is anticipated to help rectify this imbalance. Yet, the ability of each small hospital to do the conversion by itself was an impossible task. The assistance we have received through the FLEX program has allowed us to celebrate a success, which in today's healthcare environment are few and far between for hospitals like us.

If FLEX disappears, we may also travel the same road. To date we have had assistance in policy/procedure development, quality assurance oversight and clinical and site preparation. We have received a mini-grant to work with the local High School business programs to help us conduct a community survey as to needs assessment and support. Another mini-grant was awarded to help us defray some of the expensed incurred as the Coeur d' Alene Tribal Community Health Clinic (Benewah Medical Center) and we explored ways to turn our family practice clinic into an outreach program as a satellite community health clinic. Without this assistance, we could not afford the expenses required to even begin such a big but important project.

Our biggest fear is to have a successful program that is a mainstay for rural facility survival to disappear. The program was begun to support the fragile environment of rural America. We need this program to continue or the last two years of FLEX assistance was for nought. We need support to provide the expertise we cannot afford, such as outreach education, assistance in Board strategic planning, networking as CAH facilities, and access to the experts. Supporters of the FLEX program can be assured that money allocated to it is well spent and goes a long way in keeping healthcare viable in rural Idaho.

HARMS MEMORIAL HOSPITAL DISTRICT • AMERICAN FALLS, IDAHO

Harms Memorial Hospital District is located at American Falls in Power County, Idaho and serves about 8,500 residents. The hospital is a tax district. Also included in our service area is southwestern Bingham County, which includes Aberdeen, with a population of about 1,400 residents. Part of Power County has low population density with some residents having to travel significant distances to access healthcare. A large portion of the population served is eligible for Medicaid or Medicare benefits. About 60% of the clinic and hospital business is Medicare or Medicaid. The population base for the area served by the hospital is approximately 20% Hispanic. This population normally has limited resources to provide for their healthcare needs, a gap in needs, which the hospital tries to fill to the best of our ability.

The hospital serves as the destination for the local ambulance system and provides support for the EMS personnel. The hospital district operates a medical clinic that is in the process of being approved as a rural health clinic. Healthcare providers in the community support the hospital in serving the residents of Power County with a continuity of medical care. The hospital is very active in the community and participates in health fares and hosts and sponsors other activities that relate to the healthcare of our area residents.

Harms Hospital District was designed as a Critical Access Hospital effective July 16, 1999. The hospital district requested technical assistance from the Idaho Hospital Association (through the Rural Hospital Flexibility Program) providing consultation and education regarding the CAH program, designing a community education plan, needs assessment, and financial feasibility of converting to CAH status. The hospital districts' clinic has applied for rural health clinic status, which will improve the financial viability for the clinic and provider for expansion of services through the use of a mid-level practitioner. Other resources and assistance received as a result of Flex include assistance with trustee development, charge master integrity, networking opportunities, data collection for rural facilities, mini grants assisting in internal communication equipment and networking, and other networking agreements.

SHOSHONE MEDICAL CENTER • KELLOGG, IDAHO

Submitted by: **Gary M. Moore, Administrator**

Shoshone Medical Center is a 25-bed Critical Access Hospital located in the Silver Valley; Kellogg, Idaho. The Valley population is approximately 14,000 and represents 12 individual communities spread over a 25-mile radius. Beginning in the late 1800's, this beautiful mountainous area produced over 25% of the nation's silver and other metals such as gold, zinc and lead. During the 1970s most mining operations closed due to reduced silver prices and the increased cost of compliance to new EPA standards. A once thriving mining community gradually turned to one of the highest unemployed counties in the State.

With younger working families relocating out of state in search of active mines, the Valley's median age is growing and now is 41.8 years. Our local schools and SMC rely on tax subsidies to continue to provide services. SMC will have completed its first year as a Critical Access hospital in December 2001 and without this designation, SMC may not have been able to survive. The hospital and its Emergency Department offer many people access to care, without which, lives would be lost traveling over the mountain pass to the nearest hospital 40 miles away. SMC works closely with area organizations providing support such as radiographic and laboratory test for the local free clinic and providing scholarships to local high school students preparing for healthcare careers.

Over the past year, SMC has received a wide variety of support through the Flex Program from the Office of Rural Health and the Idaho Hospital Association, including stipends for needs assessment in health planning and a community Health and Safety Fair, pre-CAH survey and Quality Assurance support, Chargemaster Integrity with Cash Flow Management workshop with consultation on policy and procedures and credentialing. In additional support, the Flex Program covered the cost for one of our hospital Board members to attend the Western Regional Trustee Symposium.

Our future as a Critical Access Hospital is filled with hope and encouragement through the continued efforts of the Offices of Rural Health, the National Rural Health Association and AHA's Section of Small or Rural Hospitals. Shoshone Medical Center is currently working to fund the replacement of our 50-year-old hospital building through the HUD 242 Mortgage Insurance Program for Critical Access Hospitals. Resources such as staff and Board development programs, telecommunications systems and support, data bank networking, EMS assessments, and strategic planning with outreach programs will be essential for the continued growth and development of Critical Access Hospitals.

TETON VALLEY HOSPITAL AND SURGICENTER • DRIGGS, IDAHO

Submitted by: **Susan Kunz, Administrator**

Teton Valley Hospital and Surgicenter (TVHS), Idaho's 13th Critical Access Hospital, a 13-bed rural facility located in the Grand Teton Mountains of Southeastern Idaho. Since 1938, our facility has been dedicated to providing quality health services to the residents of and visitors to Teton County, as well as portion of north Fremont and Bonneville Counties. As the permanent resident population now nears 6,500 persons, Teton County is ranked as the 16th fastest growing in the nation and scored as Idaho's second fastest growing county.

Recent statistics show that the residents of Teton County are among those earning the lowest average per capita income and identified that 57% of the residents are living at low to moderate income levels. Census data and utilization statistics indicate that approximately 19% of the populous is Hispanic. TVHS is a county-owned facility and operates solely on patient care revenue. There are no tax dollars infused into the operation.

Within the scope of primary care, it is the mission of TVHS to provide a full array of medical services locally as well as offering community education to support health lifestyles, and prevention. We have established partnerships with all local and regional providers to enhance the provision of care in our community.

With regard to the affects of implementing the Medicare Rural Hospital Flexibility Program at our facility, operationally we have not diminished any services previously offered. Many of the staffing

flexibilities offered under CAH regulation have not been utilized because of our continuous volume. We did not find the regulatory burden to be cumbersome as most processes were already in place and functioning well. We are very hopeful that as the cost report is filed for our first year of participation that the cost based reimbursement offered under CAH will to be advantageous. Feasibility studies showed that a net gain of approximately $80,000 could be experienced. This amount of money is very significant to our facility.

The resources that the State of Idaho and its contractors have offered and continue to offer to us have been invaluable. The contract with Idaho Hospital Association to provide direction and interpretation of regulatory requirements for CAH began our relationship with the program. Because of this assistance, we experienced no deficiencies upon our initial survey. We have participated in the EMS system review and with the direction and funding provided through that process, we have provided education to our law enforcement dispatches and updated very basic equipment. Through the access grant funding, we provided scholarships to our students in nursing, ex-ray, laboratory and medical records. Our trustees were able to take advantage of the scholarship award to the Western Regional Trustee Symposium in Salt Lake City. Because of the excitement generated by their attendance, they also chose to attend the Idaho Hospital Association Convention. I have seen a renewed commitment and enthusiasm since that experience.

With regard to continuing assistance, we are hopeful that the regulatory interpretation component offered through the IHA contract will continue. This service is utilized extensively. The web site for questions and concerns have provided good insight into what other facilities are doing in the compliance arenas. We are hopeful that funding will continue for the educational experience to be offered to both our staff and trustees. We believe that support could be strengthened in the area of network development and shared services between the CAH's and their partners.

MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Submitted by: **Laura Appel, Senior Director Of Legislative Policy**

In the first two years of Michigan's Rural Hospital Flexibility Program, Michigan, through the Center for Rural Health, has provided mini grants to CAHs. In the first year the federal grant budgeted for a Quality of Care grant, a maximum of $5,000, and a Network Development grant, a maximum of $7,500 for each CAH. In the second grant year, 14 Community Health Initiative grants of $10,000 were offered and three Innovative Network Development grants of $25,000 were offered on a competitive basis. Following are highlights of some of the grants approved under the Flex Program.

- Together, **Leelanau Memorial Health Center**, in Northport; **Paul Oliver Memorial Hospital** in Frankfort; and **Kalkaska Memorial Health Center** will use a $25,000 Innovative Network Development grant to create and implement a computerized prescription order entry delivery system in all three hospitals. Few hospitals in Michigan have this capability other than some major tertiary hospitals.
- The Quality of Care grant allowed **Mackinac Straits Hospital** in St. Ignace to provide a permanent clinic location on Bois Blanc Island. Previously, the island residents held regular clinic hours in a private home. Using the Flexibility Program grant funds, Mackinac Straits Hospital built and equipped the clinic examination room at the community center and staffs the clinic on a monthly basis. It has also established a relationship with the Mackinac Island Medical Center. "It's part of our obligation to serve both islands in our community," Rod Nelson, chief executive officer of Mackinac Straits said. "We're pleased we can do this in conjunction with the Michigan Department of Community Health and the Center for Rural Health."
- **Standish Community Hospital** was awarded an Innovative Network Development grant of $25,000 to expand and enhance its role as the community's Internet service provider. No local dial-up Internet service was available in Arena County until June 1999, when Standish took the lead to create and implement a local service provider. This year, the Bay-Arena Intermediate School District approached the hospital to assist the district with providing educators with an

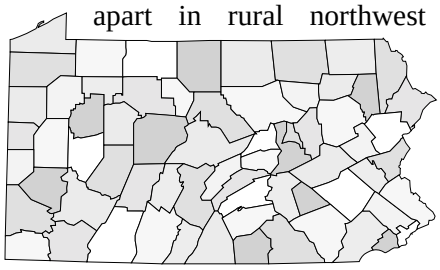
affordable Internet connection. Standish will use the Innovative Network Development grant to purchase the hardware to support the addition of the school district. Standish will also use the funding to centralize the local health and human service agencies' links to the Standish web site. The enhanced Internet service will be available from Saginaw through the I-75 corridor to Pinconning, Alger, Twining and Au Gres, areas that have been bypassed by e-information services due to their remote location.

- **Munising Memorial Hospital** will use its Community Health Initiative grant this summer to pilot a four-week summer camp program, in conjunction with the local health department, to provide therapeutic interventions for at-risk children entering kindergarten and first grade to ease the transition back to school in the fall. In discussions with the local health department and school staff, the hospital learned that limited staffing prevents assistance with the pre-academic foundation skills. In addition to the local public health department, the program is supported by several community agencies including the elementary schools, Head Start and the local parks and recreation department.
- **Scheurer Hospital** in Pigeon is using its Community Health Initiative grant to implement a diabetes education program for Huron and Tuscola Counties. Michigan ranks fourth in the nation for the incidence of diabetes. The Scheurer Hospital program will promote diabetes self-management, blood glucose control and prevention, and maintenance of acute and long-term complications from diabetes. Scheurer will use the funds to complete its certification process for the diabetes education program, enabling the hospital to bill Medicare, Medicaid and other insurance programs for the service. Patients that enter the program will be given a one-to-one consultation and attend a weekly class for four weeks. The diabetes education team will include a registered nurse, a registered dietician/certified diabetes educator, a pharmacist and an exercise physiologist.

PENNSYLVANIA STATE OFFICE OF RURAL HEALTH

Submitted by: **Larry Baronner, CAH Coordinator**

During this past year, Pennsylvania began the implementation of the Medicare Rural Hospital Flexibility Program. Fourteen hospitals were funded to conduct a financial feasibility analysis to assess whether conversion to Critical Access Hospital status would be in their interest. As expected, many of these small rural hospitals had experienced both negative operating and total margins for the past three years. Two hospitals, in particular, experienced losses in excess of $500,000 for the past fiscal year – **Union City Memorial Hospital** and **Corry Memorial Hospital**. Located 12 miles apart in rural northwest Pennsylvania, both hospitals indicated interest in considering Critical Access Hospital conversion.



Consultant presentations to the respective Boards were scheduled for Union City Memorial Hospital and Corry Memorial Hospital. These presentations would prove to be the most interesting of any in Pennsylvania, given the proximity of the hospitals and their current financial situation.

The analysis for Union City Memorial Hospital showed a modest benefit if the hospital converted to Critical Access Hospital status, certainly not enough to overcome the financial deficits. Despite this benefit, the CEO showed a reluctance to consider the option. The Board, however, voted in favor of the Critical Access Hospital option over the CEO's recommendation not to proceed. This event proved to be an indication of events to come.

The following day, the presentation at Corry Memorial Hospital proved most insightful to the healthcare picture in the region. As a percentage of operating margin Corry Memorial Hospital was doing slightly better than Union City Memorial Hospital, but as a total dollar amount, the Corry Memorial Hospital loss was greater. Critical Access Hospital status was furthermore not an option at this time for Corry Memorial Hospital due to its Geriatric Psychiatric – Distinct Part Unit. Converting to Critical Access Hospital status provided only a modest benefit to one hospital and was not an option for the other hospital unless it gave up a successful and needed service line.

An opportunity came when Union City Memorial Hospital made a leadership change. The appointment of the CFO as interim CEO opened the door to a new avenue of communication with Corry Memorial Hospital. The system parent of Union City Memorial Hospital, St. Vincent's Healthcare System, also encouraged Union City Memorial Hospital to pursue other options since Critical Access Hospital status proved not to be the entire answer to their financial problems.

In conversations with both CEOs, there was recognition that the current competitive environment between the two hospitals could not continue and that some type of collaborative arrangement needs to be formed if acute care hospital services are to be preserved in the area. As Union City Memorial Hospital had considered Critical Access Hospital status as an option, a case was made to Pennsylvania's Critical Access Hospital Coordination Committee for the use of Flex Grant monies to assist these two rural hospitals in conducting a community needs assessment and possible integration effort. The Committee agreed that this was an excellent use of the funds and approved the grant proposal.

A consultant has been selected to work on this integration effort. A kick-off meeting has been scheduled and the consultant will meet with the county's state approved Local Health Improvement Partnership, the Health Care Cost Summit of Erie County. This organization has worked in collaboration with business and healthcare organizations to collect health data for over 10 years.

Whether or not a Critical Access Hospital results from our work with Union City Memorial Hospital and Corry Memorial Hospital, given the circumstances, a Flex Grant award was the best use of, and is in the best spirit of, the Medicare Rural Hospital Flexibility Program.

SOUTH CAROLINA STATE OFFICE OF RURAL HEALTH EMS OUTREACH PROGRAM

Submitted by: **Gwen Pacella, Flex Program Coordinator**

South Carolina is near completion of an innovative EMS outreach program in four of its rural southeastern counties. The South Carolina Low Country Automatic Electronic Defibrillator (AED) Program places three AED machines and intensive training programs in each participating "low country" county. The South Carolina State Office of Rural Health through the Medicare Rural Hospital Flexibility Program (FLEX), The Robert Wood Johnson Foundation (RWJF), and the Duke Endowment joined efforts to help fund this new project. An umbrella health organization, the Low Country Health Care Network (LCHCN) collaborated with the South Carolina State Office of Rural Health and local EMS directors to develop and implement this unique EMS outreach program. The LCHCN is able to purchase the equipment in bulk thereby saving money and bringing a maximum amount of AED equipment into the region.

AEDs are cardiac resuscitation devices designed to restart a patient's heart with electric current and require the user to have a minimal amount of medical training. They are rapidly appearing in larger grocery stores, shopping malls, airplanes, and in emergency vehicles across the nation. Research in the New England Journal of Medicine demonstrates that sudden cardiac arrest is a leading cause of death in the United States and accounts for 400,000 deaths annually, almost 1,000 per day.

The American Heart Association estimates the cost of sudden cardiac arrest at approximately $193.8 billion dollars in 2001. Traditional treatment for cardiac arrest includes cardio pulmonary resuscitation (CPR) and very rapid defibrillation. Research shows that patients have a greater chance of surviving the faster the defibrillation is delivered. EMS and First Line Responders must be trained and equipped to provide defibrillation services within minutes of arrival.

The AED devices are available at minimal cost to communities and can be used by anyone with basic training. Very rural South Carolina is at great cardiac risk and its residents are 37 percent more likely to die from heart related problems and 44 percent are more likely than their urban counterparts to die of a heart attack. The AED program is essential to reducing these numbers and raising the life expectancy for rural South Carolinians.

The South Carolina Low Country AED program capitalizes on existing leadership structures in each county by inviting their EMS director to: participate in selecting an AED vendor; to distribute the equipment; and to assist in designing a training schedule for their county. Emergency Service leaders met quarterly at the Low Country Health Care Network headquarters in Denmark, SC to work on the project plans to place Automatic Electronic Defibrillators in Allendale, Bamberg, Barnwell, and Hampton Counties. Allendale County has a Critical Access Hospital and the other three counties have hospitals that are currently investigating CAH conversion. Initiating collaboration efforts is a primary goal of the LCHCN and the AED project exemplified their ability to draw entities with diverse needs around the table.

During one meeting, EMS directors and staff listened to three presentations from leading AED manufacturers. Emergency Providers were interested in the durability and use of the machines, data capacity, and future upgrade potential. After extensive discussion facilitated by LCHCN and State Office of Rural Health staff, the group voted unanimously to accept an upgradeable AED device with a portable data cartridge made by a recognized leader in advanced cardiac technology.

The LCHCN and State Office of Rural Health Flex staff will also continue to work with county EMS directors to develop training programs for paramedics and first responders. Training courses are scheduled to begin in late 2001. Without the resources provided through the Medicare Rural Hospital Flexibility Program, South Carolina would have been unable to leverage additional dollars from the Robert Wood Johnson Foundation and the Duke Endowment. These resources have been essential in assisting the rural EMS services in the four CAH-eligible counties to provide better services to their residents.

SECTION 2

Rural Hospital Flexibility Program/ Critical Access Hospitals in the News

COMMUNITY MEMORIAL HOSPITAL • HICKSVILLE, OHIO
***Hicksville News Tribune*, July 2001**

CMH Awarded Critical Access Hospital Status

Community Memorial Hospital began the new year on a positive note, receiving a long-awaited letter from the Department of Health and Human Services officially awarding Critical Access Hospital status to the hospital. CMH and Paulding County Hospital are the first two Ohio hospitals to receive the CAH designation.

Critical Access Hospital status means that Community Memorial will be reimbursed for Medicare patient charges on a "cost" basis versus the current Prospective Payment (or DRG) system. This shift in reimbursement method will mean an annual increase of approximately $400,000 to the local hospital and, according to CEO Chip Hubbs, "puts the hospital in a much stronger position to remain independent and financially viable for the long term."

The federal government developed the Critical Access program to financially assist small, rural hospitals. Originally used in states with very isolated hospitals (such as Wyoming and West Virginia), the program has gradually spread to more populated states. To be considered for CAH design, the following requirements are strictly enforced:

- No more than 15 acute patients plus 10 swing bed patients at any given time.
- An average length of stay in the hospital of less than 96 hours.
- Must have a network agreement with a larger hospital (Community Memorial signed "nonexclusive" agreements with both Parkview and Lutheran Hospitals. These agreements, however, do not restrict patients that must be transferred to a larger facility for more specialized services).

Community Memorial began its quest for CAH status over two years ago. At that time, Ohio had not yet officially adopted the program, and former hospital CEO Deryl Gulliford was diligent in pushing state and Health and Human Services officials forward in the approval process.

Once Ohio developed their state CAH program, 10 interested hospitals performed a financial feasibility study. The next step was a Community Needs Assessment, including interviews with local and area officials. The final step was a two-day intensive survey of the hospital's records, policies, facilities, etc., held in late November. Emphasis was placed on patient care issues and building safety, with the hospital receiving high marks. Only three hospitals completed the survey process: Paulding, Community Memorial, and Twin City Hospital, Dennison, OH.

**UNIVERSITY OF KENTUCKY CENTER OF EXCELLENCE IN RURAL HEALTH,
THE KENTUCKY PRIMARY CARE ASSOCIATION, AND
THE KENTUCKY RURAL HEALTH ASSOCIATION**
***Rural Health Update*, Summer 2001**
By: **Peggy Caudill, UK Center of Excellence in Rural Health**

Hospital Flexibility Program Host Romanians

The Rural Hospital Flexibility Program (RHFP) is a technical assistance program funded by the Health Resources and Services Administration's Office of Rural Health Policy to help rural hospitals with community health assessments, feasibility studies, and network development. The program has been in operation since July of 1999. The purpose of the program is to ensure financial sustainability for rural hospitals and to coordinate the delivery of integrated health services in rural communities.

The program encourages rural hospitals to engage in network development to reduce duplication of health services. Network Development leads to a community structured strategic health plan, better-informed citizens and patients, and improved community support for health care providers.

The Flexibility Program is committed to improving emergency medical services for rural communities by training emergency medical technicians. Eastern and Western Kentucky Universities provide the emergency medical service training.

In July 2001, the University of Kentucky and the Rural Hospital Flexibility Program Staff at the Center for Excellence in Rural Health had the honor of hosting three Romanian medical doctors. They were Cristina Mihai, Mona Moldovan, and Hortexzia Beciu. They were visiting Kentucky to evaluate our Health Care delivery system. The information they gathered during their visit will be utilized to develop a Rural Health Care delivery system to meet the medical needs of Rural Romanian communities.

The group spent the morning touring the new Knox County Hospital at Barbourville, Kentucky. Many inquiries were made of the administrator, John Rigby. The Knox County staff was in the progress of relocating to a new hospital that resulted from UK Center of Excellence in Rural Health's assistance with Community Initiated Decision Making (CIDM).

During the afternoon, the group toured the June Buchanan Center at Hindman, Kentucky. The group had several questions for the administrator, Don Dunn. The group of Romanian doctors received a lot of valuable information that will help facilitate their efforts. They were very appreciative of the opportunity to visit here in Kentucky.

The tour of both facilities has proven beneficial and the Romanians will return to their country with a wealth of information geared toward solving the problems of their own people.

Gifford Expects to be Designated "Critical" Hospital

Gifford Medical Center is a federal nod away from being designated a Critical Access Hospital – a distinction that is expected to bring $1 million in increased Medicare reimbursements to the Randolph hospital and help keep it viable. If approved, the Randolph hospital would be the second in the state to receive the distinction.

A visiting team of "nurse surveyors" from the Department of Aging and Disabilities' Division of Licensing and Protection spent three days at Gifford in May inspecting the hospital, interviewing staff and patients and reviewing the medical center's records, Gifford President and Chief Executive Officer Joseph Woodin explained.

At the conclusion of the visit, on May 16, Gifford department managers and staff were notified that the visit went well and that the Randolph hospital would be recommended for Critical Access Hospital approval to the federal Health Care Financing Administration.

Woodin said the federal approval seems assured and that once it's official, the designation would be effective, retroactive, as of June 1.

Grace Cottage Hospital in Townshend was the first in the state to be named a Critical Access Hospital. Woodin said the distinction not only marks the hospitals as important to the communities they serve, but places importance on rural areas in general.

"The nice thing about this is recognition, that doesn't happen very often (for) rural communities," Woodin said. "This is very good for us as a state."

To receive federal Critical Access Hospital status, the state had to create a Vermont Rural Health Plan, which it did in April 2000, and Gifford had to drop its bed count, which it did last November, by getting its Menig Extended Care Unit licensed by the state's Public Oversight Committee as a nursing home.

The nursing home's bed count was thus separated from Gifford's count, dropping it within reach of the Critical Access Hospital criteria of a maximum bed count of 25.

The Vermont Rural Health Plan identified Gifford, Grace Cottage and Mt. Ascutney hospitals as the most eligible in the state for Critical Access status. The hospitals are three of 14 community-based health care facilities in the state, all of which are operated on a not-for-profit basis. Together, the state's hospital employs 7,800 Vermonters, paying wages and benefits of nearly $400 million annually.

Gifford employs 411 Randolph area residents and will spend $13.1 million next year for its employees' wages and benefits; has clinics in the outlying towns of Rochester, Chelsea, South Royalton, Bethel and Randolph; and, like all hospitals in the state, is the only hospital in the region it serves, making it "critical" to the area.

"It's very important that we maintain those services to those communities. Those communities are really counting on us," said Woodin of the clinic locations.

"Small rural hospitals are critical to the health of rural communities, serving as a locus for preventive and primary care services, providers of acute and emergency care, and the link to specialty care, long term care and supporting services within and outside their communities," according to the Vermont Department of Health's Agency of Human Services' Vermont Rural Health Plan. "In addition, they contribute to the economic and social health of the community by providing employment and purchase of goods and services."

Many hospitals in Vermont are small and at risk of financial instability. Because each hospital is the only one in its geographic region, if one were to fail, access to essential health care services will be jeopardized for a significant percentage of the people of the region."

The Critical Access Hospital designation recognizes the importance of hospitals in the areas they serve, while also recognizing that the cost of doing business

for a small hospital is great due to lack of volume. Gifford's emergency room, for example, remains open 24 hours a day, seven days a week and must have the same equipment as a larger hospital, yet does not see as many patients that would offset the cost of 24-hour staffing and equipment, Woodin said.

The size of the hospital, coupled with low Medicare and Medicaid reimbursements, put Gifford in the red for many years. The hospital finally climbed into the black last year with a $240,000 surplus.

"Everybody should be aware of the shortfall for reimbursements for Medicare and Medicaid throughout the country and throughout Vermont," Woodin said.

The Critical Access distinction this year will mean Gifford will lose only $2 million in unpaid services for Medicare patients rather than $3 million, as the hospital will be paid under a reimbursement formula based on the cost of the care provided rather than a single fee for a hip replacement for example. Woodin said he is anticipating a 1.6-percent margin, or $364,000 surplus, this year.

Asked if the hospital was at risk of closing without the increased Medicare reimbursements, Woodin said it would have been challenging to keep going.

"One of the goals of this program is to stabilize the rural health facilities that have been at risk," Woodin said. "I think many of the rural hospitals in Vermont are faced with a lot of challenges and there are risks associated with them, yes."

Surplus dollars have already been put into a new urology program, expansion of radiology services, expansion of surgical services and a new neurologist, Dr. Daniel Sax, who has moved his practice from Boston to Randolph after 28 years visiting Vermont, according to Woodin.

Additional revenue from the Critical Access distinction will continue to be used for improved patient care and the $364,000 expected at year's end will be used for building maintenance and capital projects, Woodin said.

The hospital has just broken ground on a new ambulatory care center. The center will be build in the old birthing center space, which includes about 3,000 square feet that has been vacant since a new birthing center was completed in 1999 at the same time Menig was built. The ambulatory care center will be used as a recovery area following outpatient services such as surgical procedures or cancer treatments.

It will be named after hospital founder Dr. John P. Gifford's nephew, John P. Gifford, who recently died, Woodin said. The senior John P. Gifford, then a South Randolph doctor, started the Randolph Sanatorium Corporation, later named after its founder, in 1905.

Samaritan North Lincoln Gains Critical Access Status

Samaritan North Lincoln Hospital achieved a greater degree of financial security last week when the U.S. Department of Health and Human Services designated it a Critical Access Hospital. The designation became effective Sept. 1.

The designation was made following a written application from the hospital and a site visit by state health officials in July.

Critical Access Hospitals are rural facilities with 15 or fewer acute care beds. The designation recognizes the importance of maintaining a hospital in that location, and these facilities are reimbursed from Medicare on a cost basis rather than from the diagnostic-related groups formula typically used for inpatient care.

"The CAH designation will mean an estimated $530,000 annually in additional Medicare reimbursement," Samaritan North Lincoln Chief Executive Officer David Bigelow said. "This is a goal we have been working toward for more than a year, and we are pleased to receive this important designation. It represents an important step toward our long-term financial security and our ability to enhance services."

North Lincoln Health District board chairman Bob Mass was also pleased about receiving the designation, as gaining Critical Access Hospital status was one of the key elements in the board's financial recovery plan for the district.

"It's something we've wanted for a long time, at least since the first of the year when we found out about it," said Mass. "I think it will be very helpful in stabilizing the hospital; that's why we went after it."

Samaritan North Lincoln Hospital is one of the first hospitals in the state to achieve this designation. The Cottage Grove hospital received the designation earlier this year.

Mass added a second piece of good news for the district also arrived this week: on Monday night, the Samaritan Health Services board of directors approved and signed the Letter of Intent to affiliate with North Lincoln Health District.

The NLHD board of directors had approved and signed the letter at a special meeting Sept. 27. The letter and its terms of affiliation will be discussed in a televised public forum.

Hospital may open in June

The opening of the Critical Access Hospital in Hot Springs is very near now, according to Nursing Home Administrator John Miller and Garry Strauser of the Greater Fall River Health Services hospital workgroup.

The state Department of Health, licensing division, will conduct a survey of the facility and staffing sometime in June. The inspection includes a review of the physician call schedule, policies and nurse staffing. Then deficiencies may be issued, which must be corrected before permission is granted to open the facility.

"We make a little progress every day," said Miller. "The key things we are working on now is 24-hour RN coverage." Currently, there are two full-time nurses hired. Four full-time RNs are needed, with a few part-time nurses.

Another area that seems to be in place is physician recruitment. With the McCluskeys already having begun their practice, Lisa Brown coming to Rapid City Medical Center in July, and Dr. Art Raymond as Chief of Staff for the hospital, the group feels "confident our doctor level is OK," according to Don DeVries, Vice President of Greater Fall River Health Services.

Rapid City Regional Hospital has signed the purchasing agreement with the new hospital, the transfer agreement and the referral agreement. The last agreement is the management agreement. Greater Fall River has signed this agreement, but Rapid City Regional still has not. "I don't know what the holdup is," Noreen Petty, President of Greater Fall River Health Services reported. The management agreement calls for Rapid City Regional to provide the administrator for the hospital, and Greater Fall River will reimburse them for the cost. "We can't stop now. The commitment has been made. The nurses have been hired. The state will be here to do the survey in May," Petty said. "We're confident they'll sign."

Hot Springs will be the first town in the state to open a Critical Access Hospital "from scratch"; that is, converting a closed facility into a working hospital. All other Critical Access conversions in the state have been made to currently operating facilities.

A Critical Access designation allows the facility to have not more than 25 beds, and the maximum stay per patient is 96 hours. The advantage, say supporters, is that Medicare reimbursements for Emergency Care then cover the cost of such care, allowing the hospital to support an Emergency Room. Hot Springs has been without a public emergency room since the closure of the hospital.

The hospital was closed in December of 1998 when Banner Health Systems, who owned the facility, claimed that financial losses were greater than income. Banner later sold the building, which also contains the nursing home and assisted living, which continued to operate, to Greater Fall River Health Services, a group of local people who formed a non-profit corporation to try and save the facility. Governor Janklow offered a $150,000 Block Grant after several local citizens staged a last-minute fund raising effort to try and keep the nursing home open.

"We've come a long way," said Miller.

FIRSTHEALTH MONTGOMERY MEMORIAL HOSPITAL • TROY, NORTH CAROLINA
***FristHealth Magazine*, April 2001**

Japanese group learns about Critical Access designation at MMH

A group of financial and health care professionals from Japan visited FirstHealth Montgomery Memorial Hospital March 21 to learn how the small, rural hospital manages to keep its doors open and continually upgrade services while so many hospitals around the country struggle financially.

Members of Professor Yasuo Takagi's study group made their way over the Pacific Ocean, across the United States and into North Carolina to learn about innovative financial steps taken by rural hospitals of varying sizes. The group consisted of an interpreter, a surgeon, an internal medicine physician, a medical professor, a certified professional accountant, a personnel manager, two health care facility directors and a dentist.

In addition to Montgomery Memorial, the smallest hospital on the tour, the group visited Heritage Hospital in Tarboro, a 127-bed, medium-sized facility that was recently named a "100 Top Hospital"; and Wilson Medical Center, a 317-bed facility with strong financial operations.

The Japanese contingent was especially interested in Montgomery Memorial because of its status as a Critical Access Hospital. A response to the 1997 Balanced Budget Act, the Critical Access designation allows small, rural hospitals to base Medicare reimbursements on actual costs rather than on predetermined diagnosis-based payment.

Kerry Hensley, Vice President, Operations, told the group that Montgomery Memorial received approximately $800,000 in Medicare reimbursements in the first 18 months after it achieved Critical Access status.

"The Critical Access program is not for all small hospitals," she said later. "It works for Montgomery Memorial, because we are part of FirstHealth, which allows us to offer many services at our hospital and provide additional services to our patients through Moore Regional Hospital. Visiting Montgomery Memorial gave the group the opportunity to understand how being part of a system is key to maintaining, promoting and even developing health care in smaller communities."

A group of Japanese professionals, led by Professor Yasuo Takagi (fifth from left), recently visited Montgomery Memorial Hospital to learn about its participation in the Critical Access Hospital Program. Kerry Hensley (far left), Vice President, MMH Operations, and Finance Controller Bryan Hawkins (second from right) spoke to the group.

BROADDUS HOSPITAL • PHILIPPI, WV
ST. VINCENT RANDOLPH HOSPITAL • WINCHESTER, IN
PIONEER MEDICAL CENTER • BIG TIMBER, MT
AHA News, August 2000

When Broaddus Hospital in Philippi, WV holds its ribbon-cutting ceremony and open house Aug. 11, it will be among only a handful of the new facilities designed as critical access hospitals (CAH).

The $8 million, 45,000-square-foot facility will consist of 12 inpatient beds, a 60-bed skilled nursing facility and a 24-hour rural health clinic.

The opening of the new Broaddus facility is a tribute to the success of the CAH program, which has resulted in more than 200 certifications since created as part of the Balanced Budget Act of 1997. But it also shows the important role that community support plays in hospital viability.

More than a decade ago, Broaddus Hospital was on the brink of bankruptcy. The hospital attributes its turnaround to several factors. In 1991, a Barbour County Healthcare Referendum provided the hospital a $1.3 million tax levy. In 1994, it asked Davis Memorial Hospital to manage it and became part of the Davis Health System in 1998. And Broaddus became a CAH in 1997.

Another new CAH facility is scheduled to open in Winchester, IN, in November 2001. The 66,000-square-foot St. Vincent Randolph Hospital, formally Randolph County Hospital & Health Services, will house 25 beds and will replace the old facility that was initially designed as a women's home in 1915. St. Vincent Randolph CEO James Full said outpatient services now account for 85% of the facilities' business. He noted that the old facility was licensed for 49 beds, but used only 25.

The new facility was made possible through St. Vincent Randolph's affiliation with St. Vincent Hospitals and Health Services in Indianapolis, which is part of the Ascension Health system. The affiliation enabled the hospital to secure the necessary loans for the project, but the community chipped in 32 acres of land and a heliport, as well as monetary contributions. Full noted that St. Vincent Randolph will also receive cost-based reimbursement under the CAH program.

Holding true to its name, Pioneer Medical Center in Big Timber, MT, was a pioneer of the CAH program. It opened a new facility in 1996 as a medical assistance facility and converted to a CAH when the program began.

Pioneer received funding through donations and general obligation bonds. It has eight inpatient beds, a 52-bed skilled nursing facility and is building a 16-bed assisted-living facility. CEO Cody Langbehn said the CAH program is a very cost-feasible method of operation.

SOCORRO GENERAL HOSPITAL (CAH) • SOCORRO, NEW MEXICO

***Albuquerque Journal*, January 2001**

Sometimes things have to go very wrong before they can go very right. Just look at Socorro General Hospital. Changes in Medicare regulations in 1996 cost Socorro General $500 per Medicare admission; Medicare accounts for 30% of the payments the hospital receives in a year. On top of that, a computer system failure kept Socorro General from billing $300,000 in services.

Then the Balanced Budget Act of 1997, while providing a $150,000 annual improvement in revenues, also took away $400,000 in payments over five years.

In 1998, Socorro General lost its surgeon and with him the revenue he generated. By year-end 1999, the hospital suffered $1 million in losses – a negative 5.8% operating margin. A lot can happen in a year.

Operating margin through November 2000 was a positive 10.1% on gross revenues of $11 million. Daily hospital census increased between 1999 and 2000 from an average of 5 to 6 patients. Operating expenses per discharged patient declined from $4,000 to $3,900. The number of outpatients increased 1,000 from 1999, while home health care patient visits rose from 11,000 to 13,000.

Through it all, market surveys show patient satisfaction with the hospital improved from 1999.

It was a performance that earned Socorro General Hospital the business-of-the year award from Socorro Chamber of Commerce.

Socorro General is a single-story, 15-bed hospital on the western edge of town, on U.S. 60, across the road from a cement plant, a little before the highway disappears into the Magdalena Mountains. It serves 20,000 people in Socorro, Catron and Sierra counties.

"I can give you the $64 tour in about 10 minutes," joked hospital administrator Jeff Dye. The hub of the hospital, built in 1984 to replace an older facility near Socorro's plaza, is a compact nurse's station with a view down each of three hallways.

There is a small laboratory that handles urgent testing. A couple of rooms accommodate about 20 births occurring at the hospital each month. A part-time pharmacist presides over a small pharmacy.

Cutting across a parking lot to a modular building that houses a small gym and the hospital's physical, speech and occupational therapists, Dye stopped to pick up trash and to point out that much of the lot is dirt. "We spend the money where we generate the most service," he said.

A general surgeon has come to town, and the hospital hired a part-time podiatrist, keeping the small surgical suite busy. The emergency room handles 600 to 700 patients a month.

Just inside the lobby is a gift shop where the hospital auxiliary sells Beanie Babies to raise money. They helped the hospital but a $42,000 laparoscopic surgery system. "That's a lot of Beanie Babies," Dye said.

Down the hall from Dye's cramped office is a new CT scan system, installed at a cost of $360,000, including the room. Socorro General's parent company, Presbyterian Healthcare Services, justified the investment on the assumption it would help diagnose disease in 30 patients per month. The hospital runs 60 to 70 patients per month through the machine.

The challenge facing rural hospitals, according to Maureen Boshier, director of the New Mexico Hospitals and Health Systems Association, is that "People don't have ways to cut back on what they need in care. They need what they need." Moreover, she said, the people who provide it have to be as good in Socorro as they are anywhere else.

The problem becomes paying for the care people need when your hospital can't find people and can't raise capital, she said.

Socorro General solved the problem in 2000 by doing more with less, Dye said.

Rural hospitals are good at that anyway. There are only nine physicians with privileges to practice at Socorro General. So-called midlevels-such as nurses-carry much of the load.

For example, two nurse midwives deliver 70% to 80% of the babies. There is no anesthesiologist in Socorro, so a nurse anesthetist provides the service in the hospital's surgery. A nurse practitioner runs the emergency room and sees 75 % of the patients without any physician involvement. At night, three nurses run the entire hospital, backing each other up everywhere from the emergency room to acute-care beds.

"You have to be a generalist to work here," said nursing supervisor Veronica Pound, who grew up in Socorro and has worked in the hospital for 14 years.

Since the staff runs so much of Socorro General, Dye asked the employees to figure out how to turn things around in 2000. Pound's staff took the brunt of the changes, Dye said, by finding ways to staff what truly needed staffing so fewer work hours were required. Staffing dropped from 147 full-time equivalent employees in 1999 to 132 as of November 2000. Pay raises were also delayed.

Staff efforts resulted in a 2000 payroll of almost $300,000 less than budget, Dye said.

Socorro General Hospital staff gave up Christmas parties in 1999 and 2000. That will be rectified in February with a staff appreciation party, to be thrown with the support of Socorro Mayor and physician Ravi Bhasker on behalf of a grateful community.

St. Andrews Designated as Critical Access Hospital

St. Andrews Hospital and Healthcare Center announced Tuesday that it was named a "critical access hospital" beginning May 1 making it the third facility in New England to win this status.

In a new federal program that came out of the Balanced Budget Act of 1997, the government recognized the benefit of keeping small hospitals open by increasing reimbursement rates for services they provide. This program allows eligible rural hospitals higher reimbursement rates to provide acute care services, performing surgery, treating severely ill patients or tending to minor illnesses or injuries. The government realized without this program and the cuts in Medicare, small rural hospitals would have a difficult time surviving under the Balanced Budget Act of 1997.

This new designation will not change patient services or the care that is provided. "We are excited about becoming a critical access hospital," said Peggy Pinkham, R.N., President and CEO. "This allows us to continue to provide care and still look at ways to grow the services we provide to the community." St. Andrews focus on primary care, diagnostic technology acute care capabilities and home health care positioned St. Andrews to be a perfect candidate for this designation. St. Andrews employs 200 full- and part-time employees and is one of the largest year-round employers in the region.

The government identified fourteen hospitals in Maine as potential critical access hospitals. The program provides for the states to apply for the federal monies and Maine has as well as develops plans for implementation. As a critical access hospital, St. Andrews will receive Medicare and Medicaid reimbursements based on what it actually costs the hospital to provide the care. Up to this point, rural hospitals have been providing the same services but are paid less than the larger hospital.

Criteria for becoming a critical access hospital are: be located in a state that participates in the Medicare Rural Hospital Flexibility Program; offer 24-hour emergency services; must be located in a rural area; have no more than 15 acute care patients at any given time and patients will stay at the hospital in an acute level of care for no more than 96 hours. According to Pinkham, "This is perfect for St. Andrews as we have 20 acute care beds and six skilled bed, now we actually have an additional bed available and we are hoping to receive more skilled beds in the future so that we can take care of patients in their own community."

Already designated as Critical Access Hospitals were first Blue Hill Memorial and C.A. Dean in Greenville.

SECTION 3

American Hospital Association Critical Access Hospital Case Examples

Atoka Memorial Hospital
Atoka, Oklahoma

"Take a good look at financial feasibility, and don't depend on it to be the answer to everything. If there are operational issues that need to be addressed or attitudes in the community that are making people go somewhere else for care, becoming a critical access hospital won't fix that. Cost-based reimbursement has worked for us, but it's not what turned us around."

Paul Moore
Administrator, Atoka Memorial Hospital,
and CEO, Atoka County Health Care Authority

Background

Atoka County in Oklahoma is a low-income rural area with a population of about 13,200 and a per capita income of about $12,000, compared to $22,000 statewide. The economy of the area is primarily based on small family farms with some recreation activities like hunting and fishing. About 33 percent of the population receives some kind of transfer payment, like Social Security.

The hospital has 15 acute care beds and up to 25 swing beds, with a payer mix of 70 percent Medicare, 12 percent Medicaid and the rest equally divided between commercial and private pay. It offers both inpatient and outpatient services, as well as home health. No surgery, obstetrics, or nursing home services are offered.

CAH Experience

Financial conditions led Atoka Memorial Hospital to seek the critical access hospital designation, according to its administrator, Paul Moore. From 1996 to 1998, they had been implementing a series of operational improvements that "cut their losses," he says, such as more aggressive case management, expense reduction, cutting ties with the hospital management company, and closing the physician clinic, which, upon evaluation, was a "tremendous financial drain on the system." Even with these improvements, they still accumulated close to $1 million in net operational losses over that three-year period.

Operational losses were somewhat offset by a sales tax subsidy supported by county residents. However, it is still notable that, in 1999, Atoka Memorial's first full year as a critical access hospital, it finished in the black with a net operational gain of $319,000.

In the process of deciding whether Atoka Memorial should become a CAH, feasibility studies were conducted in-house using cost report data. In 1996, each Medicare discharge cost Atoka Memorial approximately $1,000 of unreimbursed care, which resulted in an overall loss of $303,000 for the year. Through intensive cost-cutting measures, the hospital was able by 1998 to bring the per-discharge loss down to $99, but that still resulted in a $33,000 overall loss for the year. "So it was not a hard call," he says, to decide to try for the critical access designation.

Mr. Moore encountered no resistance from the hospital's physicians or the community. Part of his strategy was to begin the process with the medical staff and "get them on board" before proceeding further. Although the community was not directly involved in the decision to become a CAH, a huge communication effort was undertaken to explain the changes to the community. Education was badly needed, according to Mr. Moore. For instance, some residents had believed that "you had to be critically ill to come to a critical access hospital." Atoka Memorial held four community meetings and was "very out front" about the potential impact of the county hospital becoming a CAH.

The hospital applied to Medicare for certification in September 1998 and became a certified critical access hospital on January 1, 1999. The survey process was "hard work," Mr. Moore says, but the Oklahoma State Department of Health was very helpful throughout the process. The hospital had to make several safety code upgrades and rework its policies and procedures in order to pass the Medicare survey.

Atoka Memorial's emergency room is staffed "24/7," he says. "It never closes." They have in-house physician assistants backed up by physicians and "one of the best trauma teams in the state." Teleradiology allows them to get a film sent or received in 20 minutes. "We've embraced the technology that's out there," Mr. Moore explains, which has helped them maintain such high-quality emergency services.

Staffing was not affected by the shift to critical access. The hospital adjusts staffing continually, based on need. No new accounting system was needed to switch to cost-based reimbursement. Cost reports needed to change some elements, but nothing else.

Working with the fiscal intermediary, Mr. Moore explains, has been a learn-as-you-go process. "We were the first critical access hospital in CMS Dallas Region 6, so there was a learning curve," he says. But overall, the FI has been very cooperative and receptive to hearing what Mr. Moore knows about the CAH program and its requirements.

Atoka Memorial does its own credentialing and quality assurance, but the hospital engages in what Mr. Moore calls "real QA" with its "upstream hospital," Texoma Healthcare System in Denison, Texas. He and his staff follow up on each patient that is transferred. Between the two hospitals, they have developed a "dynamic, interactive quality assurance process," he says. The hospital also participates in the state's peer review organization, which studies outcomes for particular illnesses.

Prior to its designation as a CAH, Atoka Memorial had already built networking relationships through the Atoka County Health Care Authority. It has a formal networking relationship with Texoma and informal relationships with some smaller hospitals plus a nearby Native American health system. With these facilities, Atoka Memorial engages in what Mr. Moore calls "real-life networking" – sharing needed resources, such as the hospital's CT scanner and ambulance services.

Lessons Learned

Mr. Moore's advice to health care leaders who may be considering CAH designation is: "Take a good look at financial feasibility, and don't depend on it to be the answer to everything. If there are operational issues that need to be addressed or attitudes in the community that are making people go somewhere else for care, becoming a critical access hospital won't fix that. Cost-based reimbursement has worked for us, but it's not what turned us around."

Thayer County Health Services
Hebron, Nebraska

"*If you wanted to create a picture of what a critical access hospital should look like, come to Hebron and see what we've done. The critical access hospital program just came along at the right time.*"

Larry Leaming, FACHE
Former Administrator/CEO
Thayer County Health Services

Background

Owned by the county, Thayer County Health Services (TCHS) acts like a health department for the county's 7,000 residents, most of whom earn a moderate income. The economy of the area is based predominantly on farming and ranching. The hospital has 14 beds, all designated critical access and which can be swing beds. Medicare and Medicaid make up approximately 65-70 percent of its payer mix.

Both inpatient and outpatient services are offered, including surgery, obstetrics, and home health. Although no skilled nursing facility is affiliated with Thayer County, a private, nonprofit, long-term care facility is located next door to the hospital. Five facilities designated Rural Health Clinics are part of Thayer County Health Services and are spread out across the service area.

CAH Experience

TCHS was involved in a huge restructuring process for five years until its completion in early summer 1999. "A feasibility study was conducted, and it would have added $200,000 to $300,000 to our reimbursement during the 1998 cost reporting period." After looking at the facts – they had an average length of stay of three days, all physicians were family practice, etc. – they realized that they "met the criteria for critical access hospitals on every front," says Larry Leaming, TCHS administrator and CEO. When the cost report analysis indicated that changing to cost-based reimbursement would add $200,000 to $300,000 to their revenue, it was an easy decision. According to Mr. Leaming, "For us, it was a slam-dunk."

Initially, the medical staff expressed some concern about the 96-hour rule, which was an absolute limit when the regulations were first released. Thayer did a retrospective study of all patients who had exceeded three days in the hospital and found that nearly all of them could have been moved to skilled nursing, swing-bed, or home health after three days. Only very few remained acute after three days. When the regulation changed to an average length of stay, no changes were necessary because the hospital's average LOS was already three days or less.

The community was not involved with the critical access conversion, but it had been very engaged in the previous restructuring of the medical services that had involved community meetings, fund-raising events, and intensive communication for the previous five years. The community had rallied behind the hospital's new design, which included only one entrance for all services, one lobby, one delivery room, one operating room – a completely integrated system with one medical record. The point here is that the one entry leads you to one lobby, one admissions area, and one business office and medical records for the entire integrated facility including hospital and physicians. It is difficult to see where the hospital stops and the physicians' clinic begins. "We've eliminated all the duplication we could. If you wanted to create a picture of what a critical access hospital should look like," Mr. Leaming explains, "come to Hebron and see what we've done. The critical access hospital program just came along at the right time."

Thayer County Health Services applied for certification in August 1999 and became a certified critical access hospital on November 1, 1999. The only difficulties experienced in the survey process, according to Mr. Leaming, were due to the newness of the program. The state's Department of Health and Human Services "had to figure out what to look for," he says. The state association helped, as did other hospitals that were also trying to determine the best way to word policies and procedures. Mr. Leaming calls it a "learning process" for everyone involved.

No changes were necessary in staffing as a result of the hospital's conversion to critical access. The facility, which includes the emergency room, is staffed with two registered nurses 24 hours a day. Four medical doctors, two physician assistants, and one nurse practitioner share on-call responsibilities. Many staffing changes had accompanied the restructuring effort, although no positions had been eliminated. Responsibilities were combined and duplication of services was eliminated or decreased. As a result, overall capacity and volume were increased dramatically.

The critical access conversion did not require changes to the financial accounting system either. In fact, Mr. Leaming seems to wish more changes had been required. "They're just not thinking like a cost-based system," he says of CMS and the other organizations involved in creating the critical access program. He expresses strong feelings about how much time, energy, and money still must be expended on coding and paperwork to meet the program's requirements. "If I were paying this hospital on a cost basis, I'd try to eliminate all the paper work possible and get down to paying for health care."

Working with the hospital's fiscal intermediary, Blue Cross Blue Shield of Nebraska, has been a positive experience for Mr. Leaming. He explains that they were "very proactive working with critical access hospitals," acted more like a "working partner," and "it didn't take them long to put together the fiscal end of things."

The hospital has been doing its own credentialing and quality assurance for 50 years, so the requirement that a tertiary hospital be involved with those aspects of the organization seems unnecessary to Mr. Leaming. The regulations, he says, tend to show very little understanding of rural health care delivery. "Every time I turn around," he explains, "there's a new regulation, requiring more paperwork, more committees, and more complicated office procedures. Why are they forcing me to do things that just add cost?" He wants to be able to put resources into the clinical side of the equation, into improving patient care.

TCHS has a networking agreement with St. Elizabeth Regional Medical Center in Lincoln, Nebraska. The agreement is not related to transfers or referrals, which Mr. Leaming says "have always been based on patient need." Only quality assurance and credentialing are covered by the agreement, along with evaluation, which they are still in the process of developing. According to Mr. Leaming, they haven't "jumped through that hoop yet."

With the added revenue from the critical access program, Mr. Leaming hopes to: (1) "have a bottom line" for the first time in several years; (2) focus on retaining "quality staff who are well-trained;" and (3) ensure that the hospital has the technology to keep delivering high-quality care.

Lessons Learned

His advice to hospital leaders who may want to consider utilizing the critical access program is to look at their average daily acute care census, which should be less than 15, and their average length of stay, which should be less than 96 hours. If the hospital meets those criteria, checking out a cost report can quickly show if the hospital could gain a financial advantage from cost reimbursement. "If the financial advantage is significant enough and you don't have to change the way you practice, it's an easy decision," he says. If the population is growing or if major changes would be necessary to comply with critical access hospital regulations, then he suggests that the program may not be appropriate.

Oneida County Hospital and Nursing Home
Malad City, Idaho

"In general, no significant changes were necessary in order to convert to critical access because we found that we were operating like that anyway."

Todd Winder
Administrator and CEO
Oneida County Hospital and
Nursing Home

Background

Oneida County in Idaho has a population of about 4,000, and its economy is primarily based on small family farms. The median household income in the county is about $30,000, and approximately 12 percent of the residents are estimated to live below the poverty level.

The hospital has 11 acute care, swing beds, and its payer mix is about 45 percent Medicare, 20 percent Medicaid, and the rest commercial or private pay. Oneida County Hospital and Nursing Home offers outpatient services, home health, a skilled nursing facility, both inpatient and outpatient surgery, and obstetrical services.

CAH Experience

According to Todd Winder, Oneida County Hospital's administrator and chief executive officer, reimbursement issues led the hospital to seek designation as a critical access hospital. "We wanted to recoup at least our costs," he says.

No resistance was encountered from the community, which has been very supportive of the hospital. A few years ago, when there were talks about possible closure, it became clear that the community did not want to lose the hospital.

At first, Mr. Winder admits, the medical staff was "leery of the 96-hour rule," but they came around quickly. After all, the hospital was already moving patients into swing beds after four days. In general, no significant changes were necessary in order to convert to critical access because, as Mr. Winder says, "we found that we were operating like that anyway."

The hospital performed three feasibility studies. The first one used a form created by the state association and was conducted internally; the second was done by an accounting firm that specializes in cost reports; and the third was done by a Montana accountant who had experience with the Medical Assistance Facility (MAF) program, a forerunner of the CAH program in Montana. Although results differed somewhat, Mr. Winder says, the message was the same – as a CAH, they would make more money. According to the estimates, the hospital would gain between $110,000 and $125,000 a year by converting to critical access.

Oneida County Hospital and Nursing Home applied for certification in February 1999, was inspected in June, and received its certification as a critical access hospital in July 1999. They experienced no difficulties in the survey process. "The regulating agency was excellent," Mr. Winder says.

Staffing has not changed. The emergency room continues to be staffed by a nurse 24 hours a day. The CAH program's financial requirements, however, have prompted the hospital to purchase a new software system that tracks transactions, but Mr. Winder does not expect to change how they gather or input data.

Dealing with the fiscal intermediary has been difficult for the hospital. Even after Oneida County Hospital received its certification, "the FI wasn't ready to deal with a CAH," according to Mr. Winder. For example, he says, the FI was unfamiliar with an 855 bill, and even after CMS clarified the rule regarding outpatient lab charges, the FI continued to tell beneficiaries that they owe a copayment, for which they are actually not responsible under the critical access system. The state association was very helpful in getting CMS to recognize the problem, Mr. Winder says, but the FI's practices have not yet changed. He promises, "We're tracking it."

A nearby hospital has had "monumental problems" with the FI, according to Mr. Winder, which resulted in no payments to the hospital from March until August 1999. This kind of difficulty has him worried. "I am very concerned about the new [outpatient prospective payment system] changes to the APCs," he says. "They don't apply to CAHs, but CMS may not know that. They say they understand, but I'll believe it when I see it."

Oneida County Hospital performs both credentialing and quality assurance in-house. The state association checks their credentialing files for accuracy and reviews their QA activities. The hospital is also part of the Maryland Quality Indicator Project, which is used for benchmarking.

The hospital has one formal networking agreement, though they refer to several other hospitals as well. The medical staff insisted on the freedom to refer to whichever facility makes the most sense in terms of the patient's treatment.

The hospital's performance will be evaluated based on whether it meets financial expectations. The evaluation will take place at the end of 2000, when the first cost report will be released following the hospital's certification as a CAH. Mr. Winder expects the most significant difference to show up in outpatient services. Although they continue to be paid according to the fee schedule for these services, they anticipate a settlement at the end of the year.

Lessons Learned

Mr. Winder advises health care leaders who are considering a shift to critical access that such a move requires careful study, especially from a financial perspective. "It doesn't make the problems we're used to go away," he warns. "We still have to be just as frugal as ever."

He is also concerned that "some providers might ruin the system by milking it. In order to keep the CAH program intact, he hopes that providers will "use the system as it was intended."

John and Mary E. Kirby Hospital
Monticello, Illinois

"It was survival of the fittest that prompted the hospital's decision to seek designation as a critical access hospital. Cost reimbursement was essential because PPS was going to be our demise."

Thomas Dixon
Administrator
John and Mary E. Kirby Hospital

Background

Monticello, Illinois, is a small, rural town with a population of 4,600 located in Piatt County, which has a population of 16,500. About 15 percent of the county's residents are over the age of 65. The area's economy is primarily agriculture based.

With 16 acute care swing beds, John and Mary E. Kirby Hospital is the smallest hospital in Illinois. Articles in local and national publications have highlighted the 60-year-old hospital's "cozy livingroom of a lobby" and its "white shutters and red bricks" that make it feel more like a house than a hospital. Kirby offers both inpatient and outpatient services, and Medicare makes up about 80 percent of its inpatient and 50 percent of its outpatient payer mix. Although the hospital has no home health program or skilled nursing facility, it is affiliated with two home health agencies and has an agreement with a 99-bed SNF located next to the hospital. Kirby is also affiliated with two rural health clinics in the area.

CAH Experience

It was "survival of the fittest," according to Kirby Hospital's administrator, Tom Dixon, that prompted the hospital's decision to seek designation as a critical access hospital. Cost reimbursement was essential, he says, because "Prospective Payment System was going to be our demise."

They encountered no resistance from the hospital's community or its medical staff about becoming a CAH, though Mr. Dixon says he had to "explain it very well." Community support has never been a problem, he says. Kirby's board, medical staff, and general staff surveyed the community about four years ago, which resulted in a building program that raised $1 million in 1.5 years, which far exceeded the hospital's initial goal of $400,000.

Feasibility studies, which were conducted by an accounting firm, indicated that becoming a critical access hospital would increase annually, with reimbursement for inpatients $172,000, and more than $232,000 for outpatients. Kirby was the first hospital in Illinois to apply for critical access status in November 1998. It became a certified CAH on August 8, 1999.

The hospital encountered some delays in attaining CAH certification due to the survey process, mostly as a result of the Life Safety Survey and CMS's November move from one address to another, which apparently caused the surveying agency to lose Kirby's original CAH Medicare Packet. Some deficiencies in the hospital's policies and procedures were identified and later resolved. Mr. Dixon credits help from the director of CMS's Region V office, Ms. Dorsey LaCompte, the Illinois Hospital and Health System Association; Ms. Barbara Dallas, VP Rural Hospitals Section, the Illinois Department of Public Health Section, and Ms. Mary Catherine Ring, chief, for being instrumental in Kirby's process of attaining certification as a Critical Access Hospital

Kirby Hospital's emergency room is staffed 24 hours a day by five physician assistants who work in conjunction with on-call physicians. Staffing changes have been needed since becoming a Critical Access Hospital due primarily to the renovations and additions with construction and increases in both outpatient and inpatient volume.

Changes have been made to the accounting system, Mr. Dixon explains, because the hospital has modified the way finances are handled. A Medicare Cost Report was completed and forwarded to the Fiscal Intermediary at the end of the fiscal year on June 30, 2000, of which they expected to receive a lump sum payment. Mr. Dixon says that the hospital's independent auditing firm and FI staffs have both been very professional and accommodating in working to resolve any CAH costs and reimbursement.

The medical staff conducts quality assurance, performance improvement, and credentialing, and the governing board approves these based on the medical staff's recommendations.

Kirby Hospital is affiliated with several hospitals, including Carle Foundation in Urbana, Decatur Memorial, and Springfield St. John's (especially for its burn unit), as well as several specialists. Kirby was the first hospital in Illinois to establish a telemedicine system, which began in 1994 with Carle Hospital and later included Decatur Memorial, that allows communication in a live setting via voice and vision with medical specialists at larger medical centers. Teleradiology is also available with Decatur radiology physicians.

Lessons Learned

Mr. Dixon offers the following advice to other health care leaders who are considering becoming a critical access hospital:

- Networking with other entities "takes a lot of work and cooperation, but it saves money" in reducing the need to duplicate services.

- "Look at the bottom line and how advantageous cost reimbursement would be. It doesn't work for everyone."

- The surveying process is tedious and complex, it can become frustrating and more complicated if individuals from the surveying agency and/or the hospital take on an adversarial attitude—the parties must have a mutual working relationship, otherwise the process is delayed."

Southwest Georgia Regional Medical Center
Cuthbert, Georgia

"Consider that this might not be the final answer, but it's the answer right now."

Keith J. Petersen, CEO
Southwest Georgia Regional Medical Center

Background

The service area covered by Southwest Georgia Regional Medical Center includes the four poorest counties in the state. A recent study also shows that Randolph County, where the hospital is located, is the county with the state's poorest health status. The economy in the area is primarily based on the logging industry and agriculture.

The hospital has 40 acute care beds and 80 skilled nursing beds, though the CAH designation requires use of no more than 15 acute care beds and 10 swing beds at any one time. Payer mix is 80 percent Medicare/Medicaid, 9 percent insured, and "11 percent self-pay, which for us is mainly no-pay," CEO Keith Petersen explains. Outpatient services are offered, as well as outpatient surgery, although they are currently working toward providing limited surgeries that require an overnight stay. "Mostly, it's a manpower issue," he says, that requires maintaining CRNA coverage.

CAH Experience

Mr. Petersen came to the hospital in March 1998, very soon after it had developed an agreement to work with Phoebe Putney Memorial Hospital, a 400-bed tertiary hospital in Albany, Georgia, which is about 50 miles away. During Southwest Georgia Regional Medical Center's strategic planning process, the state brought out its critical access hospital program. The hospital decided at that time to evaluate it as a possibility for increasing revenue. Part of the program's appeal, Mr. Petersen says, was that it seemed to be "not too hard to get into, and we could get out of it if it didn't work out." Like many other critical access hospitals, their first concern was the survival of the hospital.

The hospital communicated actively with its community during the evaluation and implementation process. They used town meetings, and created a task force made up of community leaders that met monthly during the decision-making process and continue to meet every other month. The county commissioners were given an active role in the process, and the hospital conducted a phone survey that included interviews with more than 400 residents.

The two biggest concerns expressed by the community were: (1) keeping the emergency room open, which was especially important to employers in the area that run logging operations, and (2) wondering if the effort was "really a euphemism for closing the hospital." Once these concerns were addressed, the community became very supportive.

No resistance to the critical access effort was encountered from the hospital's medical staff, which consists of five physicians, two of whom practice at Phoebe Putney and the rest who work at the affiliated rural health clinic across the street. Mr. Petersen is "very impressed," he says, with his medical staff's ability to reduce length of stay in compliance with the critical access requirements. Average length of stay started at 4.2 days, decreased to 2.7, and seems to be stabilizing at 3.2. He praises his doctors' willingness to "take care of what they can and ship out what they can't."

To determine the feasibility of becoming a critical access hospital, Southwest Georgia Regional Medical Center did a financial analysis, which was paid for by the state and conducted by a consultant group. The analysis indicated that the hospital would gain $180,000 a year in revenues. A cost study conducted by an accounting firm showed a similar figure. Although, at the time of this interview, the hospital had not seen the final numbers yet for the fiscal year, Mr. Petersen said it looks like the number is "pretty accurate." He plans to use the money to offset operating losses.

Southwest Georgia Regional Medical Center started the process of working with the state to become a CAH in August 1998, which made it the first hospital in Georgia to do so. By the end of 1998, the hospital finished the application process, and in July 1999, they were certified as a CAH, retroactive to June 25, 1999.

Mr. Petersen shared glowing comments about the survey itself and the people who conducted it. "I've been a health care executive for 25 years," he said, "and this was the best survey I've been through." Six people came to the facility who approached the project like "coaches," he explained. They helped the hospital take a closer look at the significant areas as well as the "silly things," such as the fact that they had stopped performing obstetrics services five years ago but had never modified their bylaws to reflect the change. The survey was an "educational" and "positive" experience, he said, and "their goal was for us to pass."

No staffing changes were required by the transition to critical access. The hospital's ER is staffed with on-duty nurses who can call a local physicians' group during the night and weekend shifts and the nearby rural health clinic's physicians during the day. The internal accounting system also was not changed, except for the new provider number, which took a long while to obtain, according to Mr. Petersen. It became the one issue, he said, with the fiscal intermediary, which is Blue Cross Blue Shield, in that the FI was "quick to cancel the old number and slow to process a new one." The FI ultimately made an interim payment to the hospital while it waited for the new provider number. Mr. Petersen attributes the problem to the "newness of the program."

The hospital does its own credentialing and quality assurance, though it utilizes Phoebe Putney when necessary. Its main network connection is with Phoebe Putney, including a transfer agreement, but physicians are not limited in any way from referring to other hospitals if they prefer.

Some of the "unexpected good consequences" of becoming a CAH, according to Mr. Petersen, include the following:

- Blue Cross Blue Shield has reduced discounts for the hospital to 5 percent or less because of its critical access designation.
- Medicaid pays full emergency room charges for CAHs in Georgia.
- Medicaid provided interim payments for three years of operations because the hospital is a CAH.
- CAHs are exempt from outpatient PPS, and "who knows what kind of a hit that one will be."

The state has been very supportive of rural initiatives, Mr. Petersen says. Both the governor and the lieutenant governor have expressed support for the critical access hospital program, and the governor actually visited the hospital, which was a major event, according to Mr. Petersen, since "the governor doesn't come to Cuthbert very often."

Lessons Learned

Mr. Petersen gives the following advice to health care leaders who are interested in becoming CAHs:

- "Be relentless. Don't let the obstacles bother you too much. Focus on your goal of getting there."
- Talk to other hospitals that have gone through the process.
- Get "community support and buy-in." To achieve that goal, they "really talked to a lot of people."
- Genuine partnerships are essential, like the one with Phoebe Putney that Mr. Petersen describes as a "two-way street."
- Consider that "this might not be the final answer, but it's the answer right now."

FirstHealth Montgomery Memorial Hospital
Troy, North Carolina

"While you want to look at the financial feasibility of becoming a CAH, you also want to meet the needs of the community you serve. Choose a partner hospital that will help improve the services you provide as well as the health status of your community."

Kerry Hensley, RN
Administrator, FirstHealth Montgomery Memorial Hospital

Background

Montgomery County in central North Carolina is a low-income rural area with a population of 24,382 and a per capita income of $16,000. The economy of the area is primarily based on textiles, lumber, and furniture. The unemployment rate is 6.7 percent as compared to North Carolina's rate of 5.1 percent.

Montgomery Memorial is a 25-bed critical access hospital, including acute and swing beds, meeting the health needs of the people in the county as well as surrounding communities. Inpatients at the hospital are heavily Medicare (75.7 percent) while the remainder includes commercial insurance (12.1 percent), self-pay/charity (6.2 percent), and Medicaid (6.0 percent). The hospital offers inpatient, outpatient, and 24-hour emergency services as well as long term care services in its 51-bed distinct part skilled nursing facility. The principle diagnoses of the patients include hypertension, congestive heart failure, diabetes, upper respiratory infection / pneumonia, injuries from falls, and headaches.

CAH Experience

In the late 1980s and early 1990s Montgomery Memorial Hospital, like so many other small-rural hospitals across the country, was suffering financially. To counter this continuing decline in revenue the hospital undertook several initiatives such as renovating an under utilized area of the facility for use as a long-term care unit and constructing a new area for outpatient services. County government helped subsidize operations by contributing money annually to the not-for-profit hospital.

Despite these efforts, the hospital found itself facing several more hurdles. The number of physicians admitting patients fell to two in 1994. The county subsidy, which had been on the decline for three years, was not likely to be continued. Staff morale was low and benefits were not competitive. There was also growing competition from nearby facilities, which primarily were targeting the commercially insured market.

It became clear that all the efforts over the past 5years were not enough to sustain the hospital into the future. It was at this time that the hospital Board of Trustees turned once again to the North Carolina Office of Rural Health for help. With the assistance of Jim Bernstein and his staff we planned a course that lead to our merger with Moore Regional Hospital (MRH).

The decision to merge with Moore Regional Hospital came in 1995. The two hospitals created a new corporation – FirstHealth of the Carolinas. This gave Montgomery Memorial a referral hospital as a partner in its efforts to continue to offer services in Montgomery County. FirstHealth built a new Medical Arts Center for physicians adjacent to the Montgomery Memorial and opened Family Care Centers (physician offices) in four of the county's five towns. Services were enhanced at Montgomery Memorial, but the hospital still was not operating in the black in the late 1990s.

Montgomery Memorial's administration started to consider changing its status to a CAH as a way for the hospital to move toward a positive bottom line and be more of a financially contributing part of the overall health network. The hospital became designated a CAH in April of 1999. One of the keys to being a successful CAH is having a strong relationship with the referral hospital. Montgomery Memorial had that through the merger to create FirstHealth. No agreement needed to be negotiated; the relationship was already in place with Moore Regional. "Our success as a CAH has been enhanced by our relationship with MRH such that their services can come here to help improve our services. Our merger permitted us to get into a much deeper relationship than would otherwise have been possible," says Ms. Hensley.

Montgomery Memorial's status as a CAH helps both hospitals. Montgomery Memorial gets cost-based reimbursement from Medicare for the patient's visit. If that same patient is transferred to Moore Regional, MRH gets the full payment on the Medicare DRG. Previously, the two hospitals split a single DRG payment from Medicare. Medicare payments to Montgomery Memorial increased. Payments for Medicare inpatients went from 56 percent of charges before CAH to 64 percent of charges after CAH. For outpatients, the Medicare payment rate went from 40 percent to 48 percent of charges.

In addition to the financial improvement – approximately $400,000 additional reimbursement annually – there has also been significant improvements in the quality and availability of services. Improvement in hospital processes such as weekend availability of rehab services, discharge planning and medical transcription have contributed to the reduction of our average length of stay from 4.2 days to 2.9 days during fiscal year 2000.

"The benefits of our becoming a part of a larger healthcare system have brought health services to our community that previously we could only dream about," said Hensley. Today we have school-based health centers that serve all students who attend our public schools, a dental care center that serves Medicaid and uninsured children, a transport van that brings patients for services both locally and to our partner hospital about 35 minutes away as well as a Community Health division that works with local agencies and organizations to coordinate services in order to maximize the benefit of our local resources.

Lessons Learned

Critical Access Hospitals should work with their partner / referral hospitals to do more than just accept their transfers and referrals. The CAH program was designed to strengthen rural health services. By being creative and capitalizing on the flexibility allowed by the program communities can not only improve their hospital's bottom line but also expand and strengthen available health services.

SECTION 4

Rural Health Works
Critical Access Hospital Reports

From Critical Condition to Critical Access

Saving an Oklahoma Hospital and the Local Economy

Atoka Memorial Hospital in Atoka, Oklahoma, was on the verge of shutting down, endangering the community's health and economy. *The Problem*: it was losing more than $150,000 a year. *The Solution*: becoming a Critical Access Hospital (CAH).

Built in the late 1950s, Atoka Memorial Hospital, the sole provider in Atoka County, serves some 13,200 people from the county and surrounding areas. Like most rural hospitals, it plays two vital roles: ensuring access to quality health care while anchoring the local economy. Therefore, keeping the doors open means keeping both people and the economy healthy.

"Our hospital had to do something in order to keep its doors open, and CAH was an important step in the right direction."

Keeping the doors open, however, was proving an impossible challenge. Losing more than $150,000 a year, largely as a result of changes in federal reimbursement rates, the hospital simply could not survive.

Faced with this situation, Atoka Memorial Hospital's administrator Paul Moore called on community leaders to participate in a health planning process and look for a way the hospital could become profitable again. They found it in the Critical Access Hospital designation. According to Moore, "Our hospital had to do something in order to keep its doors open, and CAH was an important step in the right direction."

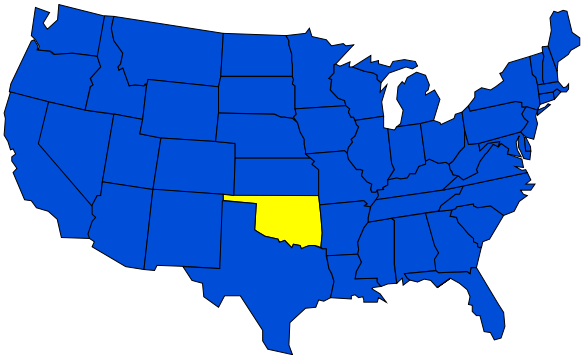
CRITICAL ASSISTANCE

Created by Congress in 1997, Critical Access Hospital designation allows hospitals to receive cost-based reimbursement from Medicare and Medicaid (state option) for inpatient and outpatient services, improving their bottom line dramatically. It also gives hospitals relief from stringent staffing requirements, allowing them to tailor their staffing to better fit community needs.

"The Flex Grant Program gave us the resources to help our small rural hospitals survive."

Converting to CAH, however, takes time and effort. To help Atoka Memorial Hospital and hospitals like it, Congress created and in 1999 began funding the Medicare Rural Hospital Flexibility Grant Program. This program provides grants ($25 million in 2001) to states to help rural hospitals and their communities consider conversion to CAH, strengthen local EMS, and improve access to quality services. "Without that assistance," said Val Schott from the Oklahoma State Office of Rural Health, "rural hospitals simply wouldn't have the resources necessary to convert to CAH. The Flex Grant Program gave us the resources to help our small rural hospitals survive."

Using funds from the federal program, the state of Oklahoma gave Atoka Memorial Hospital a grant to conduct the necessary fiscal analysis and work with the community. "The money and technical assistance from the state is just what we needed," said Moore.



CRITICAL DIFFERENCE

Assistance from the state in converting to CAH can mean the difference between life and death for many rural hospitals. For Atoka Memorial Hospital–which became a CAH in January 1999 and whose patient base is close to 70 percent Medicare beneficiaries–it meant turning that $150,000 average annual loss into a $320,000 estimated profit this year, allowing it to stay open and continue to play a vital role in the local economy.

In most rural communities, the hospital is the second largest industry in town (schools are generally the largest). Therefore, the importance of rural hospitals to their communities goes well beyond providing quality health care. A look at the numbers helps illustrate that importance.

Atoka Memorial Hospital employs 120 people and has a payroll of some $2.4 million. Those jobs and dollars, in turn, generate more jobs and dollars–what economists call the "multiplier effect." Consequently, had Atoka Memorial Hospital closed its doors and put its people out of work, those former employees would have had far less money to buy goods and services from other local businesses, hurting those businesses and the jobs and income they provide. Because of this multiplier effect, Atoka and Atoka County would have lost an additional 77 jobs and $1.3 million. Adding direct and secondary losses together, the area would have lost 197 jobs and close to $3.7 million.

In addition, the loss of the hospital would have hurt and possibly closed other health care services–the doctors, dentists, pharmacists, and nursing homes, etc.–that depend on the hospital for business. Such losses could have been huge. In Atoka County, the health sector accounts for a total impact of 619 jobs with a payroll of almost $11.4 million.

Finally, closure of the hospital and subsequent loss of other health services would have made it extremely difficult to attract and retain industry and retirees, since both look for locations with quality health care services. Simply put, had the hospital closed, the local economy would have been devastated.

CRITICAL LESSONS

Fortunately, Atoka Memorial Hospital did not close. Converting to a CAH, with funding from the federal government and assistance from the Oklahoma State Office of Rural Health, kept that nightmare from becoming a reality. Other rural communities facing the same situation would do well to learn from Atoka's experience. Specifically, communities that want to stabilize their hospitals should

- Realize that rural hospitals provide more than health care, they anchor local economies;
- Involve the community in finding ways to stabilize the hospital; and
- Contact their State Office of Rural Health for help seeking designation as a Critical Access Hospital.

If Atoka Memorial Hospital had closed, the local economy would have been devastated…

Direct Losses	Secondary Losses	Total Losses
120 Jobs	77 Jobs	197 Jobs
$2.4 Million	$1.3 Million	$3.7 Million

For more information about CAH and the Flex Grant Program, call the National Rural Health Resource Center at 218-720-0700 or the Oklahoma State Office of Rural Health at 405-271-8750.

From Critical Condition to Critical Access

Saving a Wisconsin Hospital and the Local Economy

Victory Medical Center Hospital in Chippewa County, Wisconsin, was on the verge of shutting down, endangering the community's health and economy. *The Problem*: it was losing $575,000 a year. *The Solution*: becoming a Critical Access Hospital (CAH).

Built in the early 1960s with funds from the federal Hill-Burton program, Victory Medical Center serves some 18,000 people from the county and surrounding areas. Like most rural hospitals, it plays two vital roles: ensuring access to quality health care while anchoring the local economy. Therefore, keeping the doors open means keeping both people and the economy healthy.

"CAH has assured that we can serve our rural communities."

Keeping the doors open, however, was proving an impossible challenge. Losing $575,000 a year, largely as a result of changes in federal reimbursement rates, the hospital simply could not survive.

Faced with this situation, Victory Medical Center's administrator Cynthia Eicman called on community leaders to participate in a health planning process and look for a way the hospital could become profitable again. They found it in the Critical Access Hospital designation. According to Eicman, "CAH has assured that we can serve our rural communities."

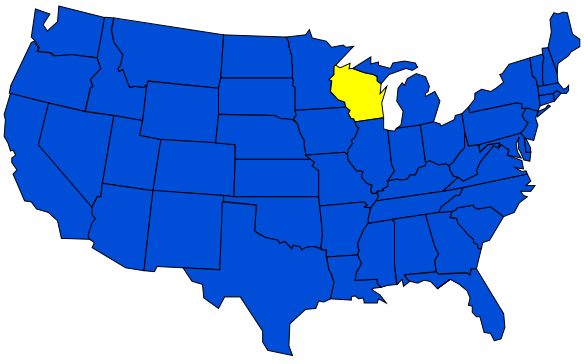
CRITICAL ASSISTANCE

Created by Congress in 1997, Critical Access Hospital designation allows hospitals to receive cost-based reimbursement from Medicare and Medicaid (state option) for inpatient and outpatient services, improving their bottom line dramatically. It also gives hospitals relief from stringent staffing requirements, allowing them to tailor their staffing to better fit community needs.

"The Flex Program is working…to ensure access to care and the health of the local economy."

Converting to CAH, however, takes time and effort. To help Victory Medical Center and hospitals like it, Congress created and in 1999 began funding the Medicare Rural Hospital Flexibility Grant Program. This program provides grants ($25 million in 2001) to states to help rural hospitals and their communities consider conversion to CAH, strengthen local EMS, and improve access to quality services. It provides valuable assistance to rural hospitals that otherwise simply would not have the resources necessary to convert to CAH.

Using funds from the federal program, the state of Wisconsin gave Victory Medical Center a grant to conduct the necessary fiscal analysis and work with the community. The money, coupled with technical assistance from the state and community support, has been the perfect antidote. “The Flex Program is working to keep these small, rural hospitals open to ensure both access to primary medical care as well as the health of the local economy,” said Ralph Pelkey, CAH Coordinator for the Wisconsin Office of Rural Health.



CRITICAL DIFFERENCE

Assistance from the state in converting to CAH can mean the difference between life and death for many rural hospitals. For Victory Medical Center--which became a CAH in March 2001 and whose patient base is close to 80 percent Medicare beneficiaries--it meant shrinking that $575,000 annual loss by $75,000 this year, with a plan to break even next year. That improvement has allowed the hospital to stay open and continue to play a vital role in the local economy.

In most rural communities, the hospital is the second largest industry in town (schools are generally the largest). Therefore, the importance of rural hospitals to their communities goes well beyond providing quality health care. A look at the numbers helps illustrate that importance.

Victory Medical Center Hospital employs 152 people and has a payroll of some $3.4 million. Those jobs and dollars, in turn, generate more jobs and dollars--what economists call the "multiplier effect." Consequently, had Victory Medical Center closed its doors and put its people out of work, those former employees would have had far less money to buy goods and services from other local businesses, hurting those businesses and the jobs and income they provide. Because of this multiplier effect, Stanley and Chippewa County would have lost an additional 93 jobs and $1.4 million. Adding direct and secondary losses together, the area would have lost 245 jobs and $4.8 million.

In addition, the loss of the hospital would have hurt and possibly closed other health care services--the doctors, dentists, pharmacists, and nursing homes, etc.--that depend on the hospital for business. Such losses could have been huge. In Chippewa County, the health sector accounts for a total of 475 jobs with a payroll of $13 million.

Finally, closure of the hospital and subsequent loss of other health services would have made it extremely difficult to attract and retain industry and retirees, since both look for locations with quality health care services. Simply put, had the hospital closed, the local economy would have been devastated.

CRITICAL LESSONS

Fortunately, Victory Medical Center did not close. Converting to a CAH, with funding from the federal government and assistance from the Wisconsin State Office of Rural Health, kept that nightmare from becoming a reality. Other rural communities facing the same situation would do well to learn from Chippewa County's experience. Specifically, communities that want to stabilize their hospitals should

- Realize that rural hospitals provide more than health care, they anchor local economies;
- Involve the community in finding ways to stabilize the hospital; and
- Contact their State Office of Rural Health for help seeking designation as a Critical Access Hospital.

If Victory Medical Center had closed, the local economy would have been devastated…

Direct Losses	Secondary Losses	Total Losses
152 Jobs	93 Jobs	245 Jobs
$3.4 Million	$1.4 Million	$4.8 Million

For more information about CAH and the Flex Grant Program, call the National Rural Health Resource Center at 218-720-0700 or the Wisconsin State Office of Rural Health at 608-265-3608.

From Critical Condition to Critical Access

Saving a Montana Hospital and the Local Economy

Big Sandy Medical Center in Chouteau County, Montana, was on the verge of shutting down, endangering the community's health and economy. *The Problem*: it was losing $29,000 a year. *The Solution*: becoming a Critical Access Hospital (CAH).

Built in 1965, Big Sandy Medical Center serves some 2,400 people from the surrounding area. Like most rural hospitals, it plays two vital roles: ensuring access to quality health care while anchoring the local economy. Therefore, keeping the doors open means keeping both people and the economy healthy.

"CAH helped our hospital survive. It helped us stay open."

Keeping the doors open, however, was proving an impossible challenge. Losing $29,000 a year, largely as a result of changes in federal reimbursement rates, the hospital simply could not survive.

Faced with this situation, Bold called on community leaders to participate in a health planning process and look for a way the hospital could become profitable again. They found it in the Critical Access Hospital designation. According to Big Sandy Medical Center's administrator Harry Bold, "CAH helped our hospital survive. It helped us stay open."

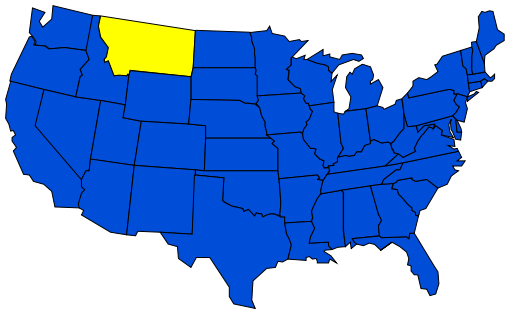
CRITICAL ASSISTANCE

Created by Congress in 1997, Critical Access Hospital designation allows hospitals to receive cost-based reimbursement from Medicare and Medicaid (state option) for inpatient and outpatient services, improving their bottom line dramatically. It also gives hospitals relief from stringent staffing requirements, allowing them to tailor their staffing to better fit community needs.

"The Flex Grant program is very important in helping the state to help keep small rural hospitals open."

Converting to CAH, however, takes time and effort. To help Big Sandy Medical Center and hospitals like it, Congress created and in 1999 began funding the Medicare Rural Hospital Flexibility Grant Program. This program provides grants ($25 million in 2001) to states to help rural hospitals and their communities consider conversion to CAH, strengthen local EMS, and improve access to quality services. It provides valuable assistance to rural hospitals that otherwise simply would not have the resources necessary to convert to CAH.

Using funds from the federal program, the state of Montana gave Big Sandy Medical Center a grant to conduct the necessary fiscal analysis and work with the community. The money, coupled with technical assistance from the state and community support, has been the perfect antidote for Big Sandy. “The Flex Grant program is very important in helping the state to help keep small rural hospitals open. Without it, many Montanans would be forced to drive considerably distances to the next ER for care, and may not make if critically injured,” said Pamela Sourbeer, Administrative Officer at the Montana Department of Public Health and Human Services.



CRITICAL DIFFERENCE

Assistance from the state in converting to CAH can mean the difference between life and death for many rural hospitals. For Big Sandy Medical Center--which became a CAH in March 1996 and whose patient base is more than 65 percent Medicare beneficiaries--it meant turning that $29,000 annual loss into a profit of $144,000 the following year, allowing it to stay open and continue to play a vital role in the local economy.

In most rural communities, the hospital is the second largest industry in town (schools are generally the largest). Therefore, the importance of rural hospitals to their communities goes well beyond providing quality health care. A look at the numbers helps illustrate that importance.

Big Sandy Medical Center employs 40 people and has a payroll of $504,000. Those jobs and dollars, in turn, generate more jobs and dollars--what economists call the "multiplier effect."

Consequently, had Big Sandy Medical Center closed its doors and put its people out of work, those former employees would have had far less money to buy goods and services from other local businesses, hurting those businesses and the jobs and income they provide. Because of this multiplier effect, Big Sandy and Chouteau County would have lost an additional 17 jobs and $126,000. Adding direct and secondary losses together, the area would have lost 57 jobs and $630,000.

In addition, the loss of the hospital would have hurt and possibly closed other health care services--the doctors, dentists, pharmacists, and nursing homes, etc.--that depend on the hospital for business. Such losses could have been huge. In Chouteau County, the health sector accounts for a total of 170 jobs with a payroll of $2 million.

Finally, closure of the hospital and subsequent loss of other health services would have made it extremely difficult to attract and retain industry and retirees, since both look for locations with quality health care services. Simply put, had the hospital closed, the local economy would have been devastated.

CRITICAL LESSONS

Fortunately, Big Sandy Medical Center did not close. Converting to a CAH, with funding from the federal government and technical assistance from the Montana Health Research and Education Foundation, kept that nightmare from becoming a reality. Other rural communities facing the same situation would do well to learn from Big Sandy's experience. Specifically, communities that want to stabilize their hospitals should

- Realize that rural hospitals provide more than health care, they anchor local economies;
- Involve the community in finding ways to stabilize the hospital; and
- Contact their State Office of Rural Health for help seeking designation as a Critical Access Hospital.

If Big Sandy Medical Center had closed, the local economy would have been devastated…

Direct Losses	Secondary Losses	Total Losses
40 Jobs	17 Jobs	57 Jobs
$.5 Million	$.1 Million	$.6 Million

For more information about CAH and the Flex Grant Program, call the National Rural Health Resource Center at 218-720-0700 or the Montana Department of Public Health and Human Services at 406-444-9519.

From Critical Condition to Critical Access

Saving an Iowa Hospital and the Local Economy

Grundy County Hospital in Grundy Center, Iowa, was on the verge of shutting down, endangering the community's health and economy. *The Problem*: it was losing $117,000 a year. *The Solution*: becoming a Critical Access Hospital (CAH).

Built in 1952, Grundy County Hospital serves about 12,300 people from the county and surrounding areas. Like most rural hospitals, it plays two vital roles: ensuring access to quality health care while anchoring the local economy. Therefore, keeping the doors open means keeping both people and the economy healthy.

"With Critical Access, we have a chance to keep up with technology, improve our hospital for everybody in the county, and keep quality health care close to home. "

Keeping the doors open, however, was proving an impossible challenge. Losing $117,000 a year, largely as a result of changes in federal reimbursement rates, the hospital simply could not survive.

Faced with this situation, hospital administrator Janice McCart called on community leaders to participate in a health planning process and look for a way the hospital could become profitable again. They found it the Critical Access Hospital designation. "With Critical Access, we have a chance to keep up with technology, improve our hospital for everybody in the county, and keep quality health care close to home," said McCart.

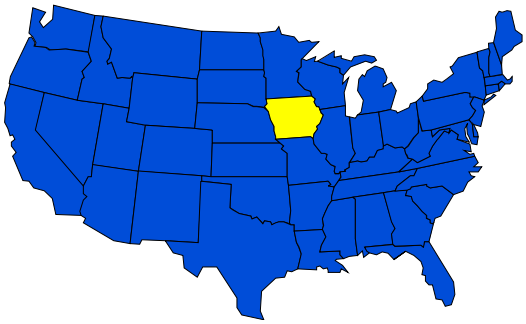
CRITICAL ASSISTANCE

Created by Congress in 1997, Critical Access Hospital designation allows hospitals to receive cost-based reimbursement from Medicare and Medicaid (state option) for inpatient and outpatient services, improving their bottom line dramatically. It also gives hospitals relief from stringent staffing requirements, allowing them to tailor staffing to better fit community needs.

"The Flex Grant Program has enabled us to help small, rural hospitals in Iowa look at CAH conversion…"

Converting to CAH, however, takes time and effort. To help Grundy County Hospital and hospitals like it, Congress created and in 1999 began funding the Medicare Rural Hospital Flexibility Grant Program. This program provides grants ($25 million in 2001) to states to help rural hospitals and their communities consider conversion to CAH, strengthen local EMS, and improve access to quality services. It provides valuable assistance to rural hospitals that otherwise simply would not have the resources necessary to convert to Critical Access Hospital designation.

Using funds from the federal program, the state of Iowa gave Grundy County Hospital a grant to conduct the necessary fiscal analysis and work with the community. The money, coupled with technical assistance from the state and community support, has been the perfect antidote for Grundy County Hospital. "The Flex Grant Program has enabled us to help small, rural hospitals in Iowa look at CAH conversion as well as do things at the state level that improve access to care," said Marvin Firch, CAH/Flex Program Coordinator in the Iowa State Office of Rural Health.



CRITICAL DIFFERENCE

Assistance from the state in converting to CAH can mean the difference between life and death for many rural hospitals. For Grundy County Hospital--which became a CAH in February 2000 and whose patient base is 60 percent Medicare beneficiaries--it meant turning that $117,000 annual loss into a profit of $13,000 the following year, allowing it to stay open and continue to play a vital role in the local economy.

In most rural communities, the hospital is the second largest industry in town (schools are generally the largest). Therefore, the importance of rural hospitals to their communities goes well beyond providing quality health care. A look at the numbers helps illustrate that importance.

Grundy County Hospital employs 120 people and has a payroll of $2.1 million. Those jobs and dollars, in turn, generate more jobs and dollars-what economists call the "multiplier effect." Consequently, had Grundy County Hospital closed its doors and put its people out of work, those former employees would have had far less money to buy goods and services from other local businesses, hurting those businesses and the jobs and income they provide. Because of this multiplier effect, Grundy Center and Grundy County would have lost an additional 71 jobs and $.8 million. Adding direct and secondary losses together, the area would have lost 191 jobs and $2.9 million.

In addition, the loss of the hospital would have hurt and possibly closed other health care services--the doctors, dentists, pharmacists, and nursing homes, etc.--that depend on the hospital for business. Such losses could have been huge. In Grundy County, the health sector accounts for a total of 710 jobs with a payroll of almost $13.5 million.

Finally, closure of the hospital and subsequent loss of other health services would have made it extremely difficult to attract and retain industry and retirees, since both look for locations with quality health care services. Simply put, had the hospital closed, the local economy would have been devastated.

CRITICAL LESSONS

Fortunately, Grundy County Hospital did not close. Converting to a CAH, with funding from the federal government and assistance from the Iowa State Office of Rural Health, kept that nightmare from becoming a reality. Other rural communities facing the same situation would do well to learn from Grundy County's experience. Specifically, communities that want to stabilize their hospitals should

- Realize that rural hospitals provide more than health care, they anchor local economies;
- Involve the community in finding ways to stabilize the hospital; and
- Contact their State Office of Rural Health for help seeking designation as a Critical Access Hospital.

If Grundy County Hospital had closed, the local economy would have been devastated…

Direct Losses	Secondary Losses	Total Losses
120 Jobs	71 Jobs	191 Jobs
$2.1 Million	$.8 Million	$2.9 Million

For more information about CAH and the Flex Grant Program, call the National Rural Health Resource Center at 218-720-0700 or the Iowa State Office of Rural Health at 515-281-7224.

From Critical Condition to Critical Access

Saving a Florida Hospital and the Local Economy

Heartland Center Hospital in Wauchula City, Florida, was on the verge of shutting down, endangering the community's health and economy. *The Problem*: it was losing more than $2.8 million a year. *The Solution*: becoming a Critical Access Hospital (CAH).

Built in the early 1970s with funds from the federal Hill-Burton program, Heartland Center Hospital, the sole provider in Hardee County, serves some 23,000 people from the county and surrounding areas. Like most rural hospitals, it plays two vital roles: ensuring access to quality health care while anchoring the local economy. Therefore, keeping the doors open means keeping both people and the economy healthy.

"Our hospital would have closed if it had not become a Critical Access Hospital!"

Keeping the doors open, however, was proving an impossible challenge. Losing more than $2.8 million a year, largely as a result of changes in federal reimbursement rates, the hospital simply could not survive. According to Heartland's administrator Mark Blondin, "Our hospital would have closed if it had not become a Critical Access Hospital!"

Realizing the importance of the hospital and the need to keep it open, Hardee County commissioners gave Heartland Center Hospital a $1 million loan to continue operating while it looked for a way to become profitable again. The hospital found that way in the Critical Access Hospital designation.

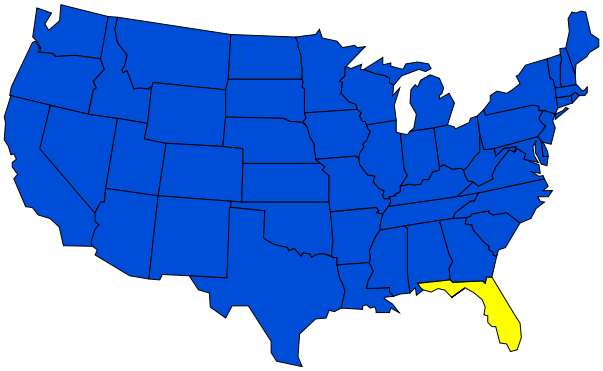
CRITICAL ASSISTANCE

Created by Congress in 1997, Critical Access Hospital designation allows hospitals to receive cost-based reimbursement from Medicare and Medicaid (state option) for inpatient and outpatient services, improving their bottom line dramatically. It also gives hospitals relief from stringent staffing requirements, allowing them to tailor their staffing to better fit community needs.

"The Flex Grant Program gave us the resources to help our small rural hospitals survive."

Converting to CAH, however, takes time and effort. To help Heartland and hospitals like it, Congress created and in 1999 began funding the Medicare Rural Hospital Flexibility Grant Program. This program provides grants ($25 million in 2001) to states to help rural hospitals and their communities consider conversion to CAH, strengthen local EMS, and improve access to quality services. "Without that assistance," said Susan Gay from the Florida State Office of Rural Health, "rural hospitals simply wouldn't have the resources necessary to convert. The Flex Grant Program gave us the grant funds to help our small rural hospitals survive."

Using funds from the federal program, the state of Florida gave Heartland Center a grant to conduct the necessary fiscal analysis and work with the community. "The money and technical assistance from the state were extremely helpful to us," said Blondin.



CRITICAL DIFFERENCE

Assistance from the state in converting to CAH can mean the difference between life and death for many rural hospitals. For Heartland Center--which became a CAH in May 2000 and whose patient base is more than 70 percent Medicare beneficiaries--it meant turning that $2.8 million annual loss into a $428,000 estimated profit this year, allowing it to stay open and repay the county commissioners. More importantly, it meant keeping the local economy afloat.

In most rural communities, the hospital is the second largest industry in town (schools are generally the largest). Therefore, the importance of rural hospitals to their communities goes well beyond providing quality health care. A look at the numbers helps illustrate that importance.

Heartland Center employs 107 people and has a payroll of some $2.5 million. Those jobs and dollars, in turn, generate more jobs and dollars-what economists call the "multiplier effect."

Consequently, had Heartland closed its doors and put its people out of work, those former employees would have had far less money to buy goods and services from other local businesses, hurting those businesses and the jobs and income they provide. Because of this multiplier effect, Wauchula City and Hardee County would have lost an additional 47 jobs and $1.2 million in so-called “secondary losses.” Adding direct and secondary losses together, the area would have lost 154 jobs and $3.7 million.

In addition, the loss of the hospital would have hurt and possibly closed other health care services--the doctors, dentists, pharmacists, and nursing homes, etc.--that depend on the hospital for business. Such losses could have been huge. In Hardee County, the health sector accounts for a total of 529 jobs with a payroll of almost $19 million.

Finally, closure of the hospital and subsequent loss of other health services would have made it extremely difficult to attract and retain industry and retirees, since both look for locations with quality health care services. Simply put, had the hospital closed, the local economy would have been devastated.

CRITICAL LESSONS

Fortunately, Heartland Center Hospital did not close. Converting to a CAH, with funding from the federal government and assistance from the Florida State Office of Rural Health, kept that nightmare from becoming a reality. Other rural communities facing the same situation would do well to learn from Wauchula's experience. Specifically, communities that want to stabilize their hospitals should

- Realize that rural hospitals provide more than health care, they anchor local economies;
- Involve the community in finding ways to stabilize the hospital; and
- Contact their State Office of Rural Health for help seeking designation as a Critical Access Hospital.

If Heartland Center Hospital had closed, the local economy would have been devastated…

Direct Losses	Secondary Losses	Total Losses
107 Jobs	47 Jobs	154 Jobs
$2.5 Million	$1.2 Million	$3.7 Million

For more information about CAH and the Flex Grant Program, call the National Rural Health Resource Center at 218-720-0700 or the Florida State Office of Rural Health at 850-245-4340.

From Critical Condition to Critical Access

Saving a California Hospital and the Local Economy

Tehachapi Valley Healthcare District in Kern County, California, was on the verge of shutting down, endangering the community's health and economy. *The Problem*: it was losing more than $900,00 a year. *The Solution*: becoming a Critical Access Hospital (CAH).

Built in 1957, Tehachapi Valley Healthcare District serves nearly 30,000 people from the local community and surrounding areas. Like most rural hospitals, it plays two vital roles: ensuring access to quality health care while anchoring the local economy. Therefore, keeping the doors open means keeping both people and the economy healthy.

If it weren't for CAH, Tehachapi Hospital would have closed.

Keeping the doors open, however, was proving an impossible challenge. Losing more than $900,000 a year, largely as a result of changes in federal reimbursement rates, the hospital simply could not survive.

Faced with this situation, the Board of Directors of the hospital called on community leaders to participate in a health planning process and look for a way the hospital could become profitable again. They found it in the Critical Access Hospital designation. "If it weren't for the CAH program, Tehachapi Hospital would have closed in 2001, leaving over 20,000 people with no nearby access to 24-hour per day emergency care. Lives would have been lost in our community, and that would have been a tragedy," said Raymond Hino, hospital CEO.

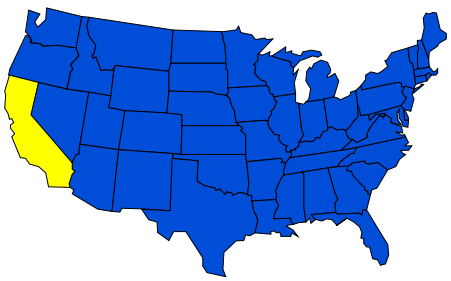
CRITICAL ASSISTANCE

Created by Congress in 1997, Critical Access Hospital designation allows hospitals to receive cost-based reimbursement from Medicare and Medicaid (state option) for inpatient and outpatient services, improving their bottom line dramatically. It also gives hospitals relief from stringent staffing requirements, allowing them to tailor their staffing to better fit community needs.

"…California would not have had the resources to help rural communities maintain access to healthcare without the Flex Grant Program."

Converting to CAH, however, takes time and effort. To help the California hospital and hospitals like it, Congress created and in 1999 began funding the Medicare Rural Hospital Flexibility Grant Program. This program provides grants ($25 million in 2001) to states to help rural hospitals and their communities consider conversion to CAH, strengthen local EMS, and improve access to quality services. It provides valuable assistance to rural hospitals that otherwise simply would not have the resources necessary to convert to CAH.

Using funds from the federal program, the state of California gave Tehachapi Valley Healthcare District a grant to conduct the necessary fiscal analysis and work with the community. The money, coupled with technical assistance from the state and community support, has been the perfect antidote for Tehachapi. "There's no question, the state of California would not have had the resources to help rural communities maintain access to healthcare without Flex Grant Program," said Ernesto Iglesias, Administrator



of the Medicare Rural Hospital Flexibility for the State of California. “Our Critical Access hospitals are truly isolated facilities. If they close, huge areas are left without medical care. The Flex Grant Program is very important to us; it helps us protect a valuable state resource,” added Sharon Avery, Executive Director of the California Rural Healthcare Center.

CRITICAL DIFFERENCE

Assistance from the state in converting to CAH can mean the difference between life and death for many rural hospitals. For the California Hospital--which became a CAH in April 2001 and whose patient base is 31 percent Medicare beneficiaries--it means turning that $900,000 annual loss into a projected profit of more than $200,000 in 2002, allowing it to stay open and continue to play a vital role in the local economy.

In most rural communities, the hospital is the second largest industry in town (schools are generally the largest). Therefore, the importance of rural hospitals to their communities goes well beyond providing quality health care. A look at the numbers helps illustrate that importance.

Tehachapi Valley Healthcare District employs 105 people and has a payroll of $2.7 million. Those jobs and dollars, in turn, generate more jobs and dollars-what economists call the "multiplier effect." Consequently, had the Tehachapi Hospital closed its doors and put its people out of work, those former employees would have had far less money to buy goods and services from other local businesses, hurting those businesses and the jobs and income they provide. Because of this multiplier effect, Tehachapi and Kern County would have lost an additional 100 jobs and $1.5 million. Adding direct and secondary losses together, the area would have lost 205 jobs and $4.2 million.

In addition, the loss of the hospital would have hurt and possibly closed other health care services--the doctors, dentists, pharmacists, and nursing homes, etc.--that depend on the hospital for business. Such losses could have been huge. In Kern County, the health sector accounts for a total of 597 jobs with a payroll of almost $11.7 million.

Finally, closure of the hospital and subsequent loss of other health services would have made it extremely difficult to attract and retain industry and retirees, since both look for locations with quality health care services. Simply put, had the hospital closed, the local economy would have been devastated.

CRITICAL LESSONS

Fortunately, the Tehachapi Valley Healthcare District did not close. Converting to a CAH, with funding from the federal government and assistance from the California Healthcare Association, kept that nightmare from becoming a reality. Other rural communities facing the same situation would do well to learn from Tehachapi's experience. Specifically, communities that want to stabilize their hospitals should

- Realize that rural hospitals provide more than health care, they anchor local economies;
- Involve the community in finding ways to stabilize the hospital; and
- Contact their State Office of Rural Health for help seeking designation as a Critical Access Hospital.

If Tehachapi Valley District had closed, the local economy would have been devastated…

Direct Losses	Secondary Losses	Total Losses
105 Jobs	100 Jobs	205 Jobs
$2.7 Million	$1.5 Million	$4.2 Million

For more information about CAH and the Flex Grant Program, call the National Rural Health Resource Center at 218-720-0700 or the California Healthcare Association Rural Healthcare Center at 916-443-7401.

From Critical Condition to Critical Access

Saving a Mississippi Hospital and the Local Economy

Monroe Aberdeen County Hospital in Aberdeen, Mississippi, was on the verge of shutting down, endangering the community's health and economy. *The Problem*: it was losing $900,000 a year. *The Solution*: becoming a Critical Access Hospital (CAH).

Built in 1966 with funds from the federal Hill-Burton program, Monroe Aberdeen County Hospital serves some 14,000 people from the county and surrounding areas. Like most rural hospitals, it plays two vital roles: ensuring access to quality health care while anchoring the local economy. Therefore, keeping the doors open means keeping both people and the economy healthy.

"I see Critical Access designation as a way for rural hospitals to survive in order to provide their communities with much needed primary care services."

Keeping the doors open, however, was proving an impossible challenge. Losing more than $900,000 a year, largely as a result of changes in federal reimbursement rates, the hospital simply could not survive.

Faced with this situation, the hospital's administrator Joe McNulty called on community leaders to participate in a health planning process and look for a way the hospital could become profitable again. They found it in the Critical Access Hospital designation. According to McNulty, "I see Critical Access designation as a way for rural hospitals to survive in order to provide their communities with much needed primary care services."

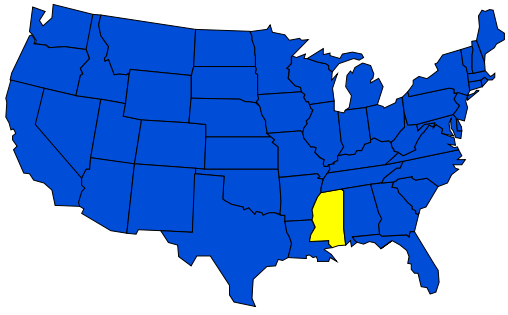
CRITICAL ASSISTANCE

Created by Congress in 1997, Critical Access Hospital designation allows hospitals to receive cost-based reimbursement from Medicare and Medicaid (state option) for inpatient and outpatient services, improving their bottom line dramatically. It also gives hospitals relief from stringent staffing requirements, allowing them to tailor staffing to better fit community needs.

"The Flex Grant Program gave us the resources to help our small, rural hospitals survive."

Converting to CAH, however, takes time and effort. To help Monroe Aberdeen County Hospital and hospitals like it, Congress created and in 1999 began funding the Medicare Rural Hospital Flexibility Grant Program. This program provides grants ($25 million in 2001) to states to help rural hospitals and their communities consider conversion to CAH, strengthen local EMS, and improve access to quality services. The Flex Grant Program provides the resources to help small rural hospitals survive.

Using funds from the federal program, the state of Mississippi gave Monroe Aberdeen County Hospital a grant to conduct the necessary fiscal analysis and work with the community. The money, coupled with technical assistance from the state and community support, has been the perfect antidote for the hospital. "Without that assistance," said David Lightwine, Director of the Mississippi State Office of Rural Health, "rural hospitals simply wouldn't have the resources necessary to convert. The Flex Grant Program gave us the resources to help our small, rural hospitals survive."



CRITICAL DIFFERENCE

Assistance from the state in converting to CAH can mean the difference between life and death for many rural hospitals. For Monroe Aberdeen County Hospital--which became a CAH in September 2001 and whose patient base is more than 90 percent Medicare beneficiaries--it means turning that $900,000 annual loss into projected zero balance next year, allowing it to stay open and continue to play a vital role in the local economy.

In most rural communities, the hospital is the second largest industry in town (schools are generally the largest). Therefore, the importance of rural hospitals to their communities goes well beyond providing quality health care. A look at the numbers helps illustrate that importance.

Monroe Aberdeen County Hospital employs 156 people and has a payroll of some $2.9 million. Those jobs and dollars, in turn, generate more jobs and dollars--what economists call the "multiplier effect." Consequently, had Monroe Aberdeen County Hospital closed its doors and put its people out of work, those former employees would have had far less money to buy goods and services from other local businesses, hurting those businesses and the jobs and income they provide. Because of this multiplier effect, Monroe County would have lost an additional 89 jobs and $.8 million. Adding direct and secondary losses together, the area would have lost 245 jobs and $3.7 million.

In addition, the loss of the hospital would have hurt and possibly closed other health care services—the doctors, dentists, pharmacists, and nursing homes, etc.--that depend on the hospital for business. Such losses could have been huge. In Monroe County, the health sector accounts for a total of 586 jobs with a payroll of $7.4 million.

Finally, closure of the hospital and subsequent loss of other health services would have made it extremely difficult to attract and retain industry and retirees, since both look for locations with quality health care services. Simply put, had the hospital closed, the local economy would have been devastated.

CRITICAL LESSONS

Fortunately, the Aberdeen Monroe County Hospital did not close. Converting to a CAH, with funding from the federal government and assistance from the Mississippi State Office of Rural Health, kept that nightmare from becoming a reality. Other rural communities facing the same situation would do well to learn from Monroe County's experience. Specifically, communities that want to stabilize their hospitals should

- Realize that rural hospitals provide more than health care, they anchor local economies;
- Involve the community in finding ways to stabilize the hospital; and
- Contact their State Office of Rural Health for help seeking designation as a Critical Access Hospital.

If Monroe Aberdeen County Hospital had closed, the local economy would have been devastated…

Direct Losses	Secondary Losses	Total Losses
156 Jobs	89 Jobs	245 Jobs
$2.9 Million	$.8 Million	$3.7 Million

For more information about CAH and the Flex Grant Program, call the National Rural Health Resource Center at 218-720-0700 or the Mississippi State Office of Rural Health at 601-576-7874.

From Critical Condition to Critical Access

Saving a Texas Hospital and the Local Economy

Winkler County Memorial Hospital in Kermit, Texas, was on the verge of shutting down, endangering the community's health and economy. *The Problem*: it was losing more than $175,000 a year. *The Solution*: becoming a Critical Access Hospital (CAH).

Built in 1949, Winkler County Hospital serves about 8,000 people from the county and surrounding areas. Like most rural hospitals, it plays two vital roles: ensuring access to quality health care while anchoring the local economy. Therefore, keeping the doors open means keeping both people and the economy healthy.

"Critical Access is our last, best hope!"

Keeping the doors open, however, was proving an impossible challenge. Losing more than $175,000 a year, largely as a result of changes in federal reimbursement rates, the hospital simply could not survive.

Faced with this situation, hospital administrator Judene Willhelm called on community leaders to participate in a health planning process and look for a way the hospital could become profitable again. They found it in the Critical Access Hospital designation. "Critical Access is our last, best hope!" said Willhelm.

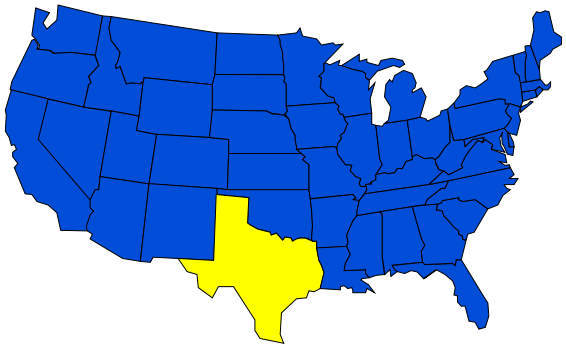
CRITICAL ASSISTANCE

Created by Congress in 1997, Critical Access Hospital designation allows hospitals to receive cost-based reimbursement from Medicare and Medicaid (state option) for inpatient and outpatient services, improving their bottom line dramatically. It also gives hospitals relief from stringent staffing requirements, allowing them to tailor their staffing to better fit community needs.

Critical Access and the Flex Grant Program help hospitals stop the bleeding and turn their operations around…

Converting to CAH, however, takes time and effort. To help Winkler County Memorial Hospital and hospitals like it, Congress created and in 1999 began funding the Medicare Rural Hospital Flexibility Grant Program. This program provides grants ($25 million in 2001) to states to help rural hospitals and their communities consider conversion to CAH, strengthen local EMS, and improve access to quality services. It provides valuable assistance to rural hospitals that otherwise simply would not have the resources necessary to convert to CAH.

Using funds from the federal program, the state of Texas gave Winkler County Memorial Hospital a grant to conduct the necessary fiscal analysis and work with the community. The money, along with technical assistance from the state and community support, has been the perfect antidote for Kermit, Texas. "Critical Access and the Flex Grant Program give hospitals the opportunity to not only stop the bleeding, but to also turn their operations around by networking with other providers and offering other services," said Mike Easley with the Texas State Office of Rural Health.



CRITICAL DIFFERENCE

Assistance from the state in converting to CAH can mean the difference between life and death for many rural hospitals. For Winkler County Memorial Hospital--which became a CAH in October 2000 and whose patient base is more than 70 percent Medicare beneficiaries--it meant turning that $175,000 annual loss into a profit of $207,000 the following year, allowing it to stay open and continue to play a vital role in the local economy.

In most rural communities, the hospital is the second largest industry in town (schools are generally the largest). Therefore, the importance of rural hospitals to their communities goes well beyond providing quality health care. A look at the numbers helps illustrate that importance.

Winkler County Memorial employs 81 people and has a payroll of $1.6 million. Those jobs and dollars, in turn, generate more jobs and dollars--what economists call the "multiplier effect." Consequently, had Winkler County Memorial Hospital closed its doors and put its people out of work, those former employees would have had far less money to buy goods and services from other local businesses, hurting those businesses and the jobs and income they provide. Because of this multiplier effect, Kermit and Winkler County would have lost an additional 47 jobs and $1 million in so-called “secondary losses.” Adding direct and secondary losses together, the area would have lost 128 jobs and close to $2.6 million.

In addition, the loss of the hospital would have hurt and possibly closed other health care services--the doctors, dentists, pharmacists, and nursing homes, etc.--that depend on the hospital for business. Such losses could have been huge. In Winkler County, the health sector accounts for a total of 459 jobs with a payroll of almost $9.6 million.

Finally, closure of the hospital and subsequent loss of other health services would have made it extremely difficult to attract and retain industry and retirees, since both look for locations with quality health care services. Simply put, had the hospital closed, the local economy would have been devastated.

CRITICAL LESSONS

Fortunately, Winkler County Memorial did not close. Converting to a CAH, with funding from the federal government and assistance from the Texas State Office of Rural Health, kept that nightmare from becoming a reality. Other rural communities facing the same situation would do well to learn from Winkler County's experience. Specifically, communities that want to stabilize their hospitals should

- Realize that rural hospitals provide more than health care, they anchor local economies;
- Involve the community in finding ways to stabilize the hospital; and
- Contact their State Office of Rural Health for help seeking designation as a Critical Access Hospital.

If Winkler County Memorial had closed, the local economy would have been devastated…

Direct Losses	Secondary Losses	Total Losses
81 Jobs	47 Jobs	128 Jobs
$1.6 Million	$1 Million	$2.6 Million

For more information about CAH and the Flex Grant Program, call the National Rural Health Resource Center at 218-720-0700 or the Texas State Office of Rural Health at 512-479-8891.

SECTION 5

Rural Hospital Flexibility Program Tracking Project's *Findings From the Field*